State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2020

Name of Facility (as licensed) Crestfield Rehabilitation Center		
Address (No. & Street, City, State, Zip Code) 565 Vernon Street, Manchester, CT 06042		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☑ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2344			07-5319

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	10140	10140	

For Department Use Only

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

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
Crestfield Rehabilitation Center	2344	9/30/2020	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 Crestfield Rehabilitation Center [facility name], for the cost report period beginning October 1, 2019 and ending September 30, 2020, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Patricia Salisbury			Printed Name (Owner) Lawrence Santilli	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

Table of Contents

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 Crestfield Rehabilitation Center	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 565 Vernon Street, Manchester, CT 06042				
Report Prepared By Athena Health Care Associates	Phone Number 860-751-3900		Date	

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
860-643-5151	9/30/2020	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Crestfield Rehabilitation Center	565 Vernon Street, Manchester, CT 06042

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2344			07-5319

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.:
Patricia Salisbury	1445

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

Name	License No.:
N/A	

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
Crestfield Rehabilitation Center	2344	9/30/2020	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
Crestfield Holdings LLC	135 South Road, Farmington, CT	CT

Name of Partners/Members	Business Address	Title	% Owned
Lawrence G. Santilli	135 South Road, Farmington, CT	Manager	0.57

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
Crestfield Rehabilitation Center	2344	9/30/2020	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
Crestfield Rehabilitation Center	2344	9/30/2020	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
Crestfield Rehabilitation Center	2344	9/30/2020	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: Yes	No	%**	Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
Athena Health Care Insurance	135 South Road, Farmington, CT 06032	○	⊙		Self insured Employee Health & Dental Insu	pg 15, ln 1a5	573,929	573,929
Athena Health Care Assocaites 401K Plan	135 South Road, Farmington, CT 06032	○	⊙		Facility participates in group 401K Plan	pg 15, ln 1a7		
Procare LTC	111 Executive Blvd, Farmindale, NY 11735	⊙	○	>50%	Pharmacy	pg 20 ln 5a2	256,291	256,291
Athena Health Care	135 South Road, Farmington, CT 06032	⊙	○	<50%	Various: See attached			
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

* 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
Crestfield Rehabilitation Center	2344	9/30/2020	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.

Patient Care Consults, Laundry, Housekeeping, Maintenance/Prop Costs, Admin - Alloc on Patient Days
Physical/Speech/Occupational Therapy - Allocated on % of Treatments Administrative Nursing - Allocated on Direct Nursing Hours Management Fees - Allocated based on methods above for each expense category

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

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

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

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

Not Applicable:No Non-Nursing Home Cost Centers

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
Crestfield Rehabilitation Center	2344	9/30/2020	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
Xerox Financial services	○	⊙	Copier	06/01/19	48 months	10,465	7,900
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙				**Total** ***	7,900

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
Crestfield Rehabilitation Center	2344	9/30/2020	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 Marcum LLP	555 Long Wharf Drive, New Haven, CT
2 MidCap Financial Services, LLC	7255 Woodmont Avenue, Bethesda, MD 20814
3	
4	

Services Provided by This Firm (*describe fully*)

1	Medicare Cost Report: Allowed	$ 2,700
2	LOC Audit/Fee:Disallowed	$ 30,695
3		$
4		$
		Charge for Services Provided $ 33,395

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

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Goldman, Gruder & Woods, LLC	203-899-8900 / 860-567-0451
2 Murtha Cullina, LLP	860-240-6000
3 Tn of Manchester, Treasurer ST of CT	
4	
5	

Address (*No. & Street, City, State, Zip Code*)
1 200 Connecticut Ave, Norwalk, CT 06854
2 185 Asylum Street, Hartford, CT 06103
3 66 Center street Manchester, CT
4
5

Services Provided by This Firm (*describe fully*)

1	A/R Collections:Disallowed	$ 3,631
2	Termination of Consent order:Allowed	$ 149
3	Conservatorship: Disallowed	$ 856
4		$
5		$
		Charge for Services Provided $ 4,636

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

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
Crestfield Rehabilitation Center	2344	9/30/2020	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	155	95	60		155	95	60					
B. On last day of THIS report period	155	95	60						155	95	60	
2. Number of Residents												
A. As of midnight of PREVIOUS report period	101	82	19		101	82	19					
B. As of midnight of THIS report period	82	75	7						82	75	7	
3. Total Number of Days Care Provided During Period												
A. Medicare	5,649	4,023	1,626		4,411	3,045	1,366		1,238	978	260	
B. Medicaid (Conn.)	24,177	24,177			18,730	18,730			5,447	5,447		
C. Medicaid (other states)												
D. Private Pay	3,846	1,612	2,234		3,338	1,161	2,177		508	451	57	
E. State SSI for RCH												
F. Other (Specify) Managed care	188	188			154	154			34	34		
G. Total Care Days During Period (3A thru F)	33,860	30,000	3,860		26,633	23,090	3,543		7,227	6,910	317	
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	25	3	22		25	3	22					
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	33,885	30,003	3,882		26,658	23,093	3,565		7,227	6,910	317	

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
Crestfield Rehabilitation Center	2344	9/30/2020	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-MR
No. of Residents	4	60		5	2		11	
Per Diem Rate								
a. One bed rm.	581.59	249.74		410.00			385.52	
b. Two bed rms.	581.59	249.74		350.00			385.52	
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	1,698	1,698		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	2,124	2,124		
2. Restorative Treatments				
C. Other	7,763	7,763		
D. ***Total Physical Therapy Treatments***	11,585	11,585		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	864	864		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	423	423		
2. Restorative Treatments				
C. Other	1,882	1,882		
D. ***Total Speech Therapy Treatments***	3,169	3,169		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	2,182	2,182		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,939	1,939		
2. Restorative Treatments				
C. Other	8,272	8,272		
D. ***Total Occupational Therapy Treatments***	12,393	12,393		

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
Crestfield Rehabilitation Center	2344	9/30/2020	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)	144,185	1,912	18,656	247		
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	254,545	9,179	32,935	1,188		
5. Dietary Service						
a. Head Dietitian	76,871	2,017	9,946	261		
b. Food Service Supervisor	78,338	1,964	10,136	254		
c. Dietary Workers	448,620	24,753	58,046	3,203		
6. Housekeeping Service						
a. Head Housekeeper	11,974	607	1,549	78		
b. Other Housekeeping Workers	252,006	15,214	32,606	1,969		
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	61,268	2,090	7,927	270		
b. Other Maintenance Workers	40,905	2,068	5,293	268		
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	123,367	6,918	15,962	895		
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	134,112	2,551	18,856	359		
b. RN						
1. Direct Care	556,553	1,409	5,461	192		
2. Administrative**	486,814	23,299	68,448	3,276		
c. LPN						
1. Direct Care	1,170,854	34,786	189,475	6,093		
2. Administrative**						
d. Aides and Attendants	1,673,517	81,184	199,525	10,547		
e. Physical Therapists	273,681	7,305				
f. Speech Therapists	91,101	2,377				
g. Occupational Therapists	229,160	6,120				
h. Recreation Workers	126,157	5,361	16,324	694		
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	183,374	5,403	23,726	700		
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	6,417,402	236,517	714,871	30,494		

* 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**
Total	$ -	-	$ -	-	$ -	-

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
Crestfield Rehabilitation Center	2344	9/30/2020	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).										

* 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
Crestfield Rehabilitation Center	2344	9/30/2020	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* **										
Patricia Salisbury	144,185	18,656				2,159	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
Crestfield Rehabilitation Center	2344	9/30/2020	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	15,576	26	2,015	3		
3. Pharmacist	6,868	132	889	17		
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker	20,306	319	2,627	41		
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	71,942	469	9,308	61		
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	6,321					
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	428	2				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	21,668	296				
2. Administrative***	3,055	49	429	7		
b. LPN						
1. Direct Care	20,718	342				
2. Administrative***						
c. Aides	4,101	138				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	170,983	1,773	15,268	129		

* 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
Crestfield Rehabilitation Center	2344	9/30/2020	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
SDX Swallowing Diagnostics, PO Box 484, Avon, CT	Speech Therapy	○	⊙	
Nurse Network, 405 Park Ave., New York, NY 10022	Nurse Pool	○	⊙	
MAS Medical Staffing, 156 Harvye Road, Londonberry, NH	Nurse Pool	○	⊙	
Procare LTC, 111 Executive Blvd, Farmingdale, NY 11735	Pharmacist	⊙	○	Common Owners: Minority Interest
Towne, 5140 US Highway 9 S, Howell, NJ	Nurse Pool	○	⊙	
Southern CT Vascular Center, 6 Research Drive, Shelton, Ct	lab services	○	⊙	
Quest Diagnostics, 3404 Collection Center Drive, Chicago, IL	lab services	○	⊙	
Health Drive Dental Group, 888 Worcester Street, Wellseley, MA 02482-3744	Dentist	○	⊙	
MASSTEX Imaging LLC, 3 Electronics Ave, Danvers, MA	Speech Therapy	○	⊙	
Norton & Associates, 34 Elm Street, Cohasset, MA 02025	Social Service Consulting	○	⊙	
Starling Physicians, PO Box 27728, Salt Lake City, Utah	Medical Director/Asst Medical Director	○	⊙	
Constantine Zariphes MD, 324 Conestoga Way, Glastonbury, CT	Medical Director	○	⊙	
Third Eye Health, PO Box 7410158, Chicago, IL	Eye Doctor	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

* 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. 9/2018

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Crestfield Rehabilitation Center	2344	9/30/2020		15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	175,530	157,937	17,593	
2. Disability Insurance	$				
3. Unemployment Insurance	$	110,405	99,339	11,066	
4. Social Security (F.I.C.A.)	$	516,450	464,686	51,764	
5. Health Insurance	$	549,202	494,155	55,047	
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	22,242	20,013	2,229	
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	56,216	56,216		
d. Accounting and Auditing	$	33,395	29,569	3,826	
e. Legal (*Services should be fully described on Page 7)*	$	4,636	4,105	531	
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	75,771	67,090	8,681	
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	18,385	16,279	2,106	
2. Cellular Phones	$	568	503	65	
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	$	597,977	529,470	68,507	
Subtotal	$	2,160,777	1,939,362	221,415	

* 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)
Total	$ -	$ -	$ -

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
Crestfield Rehabilitation Center	2344	9/30/2020	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,160,777	1,939,362	221,415	
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	3,223	2,854	369	
3. Gifts to Staff and Residents	$	12,424	11,001	1,423	
4. Employee Travel	$	1,618	1,433	185	
5. Education Expenses Related to Seminars and Conventions	$	6,185	5,477	708	
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	21,903	19,394	2,509	
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	3,613	3,199	414	
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	$	3,284	2,908	376	
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	11,529	10,208	1,321	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	625	553	72	
10. Contributions***	$				
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	144,545	127,986	16,559	
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,369,726	2,124,375	245,351	

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	$ 3,199	$ 414	
Total Other Advertising	$ 3,199	$ 414	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 10,208	$ 1,321	
Total Dues	$ 10,208	$ 1,321	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Charges	$ 37,595	$ 4,864	
Payroll Processing fees	$ 20,690	$ 2,677	
Employee Physicals	$ 12,973	$ 1,679	
Energy Audit	$ 2,952	$ 382	
Data Processing	$ 53,422	$ 6,912	
Licenses	$ 88	$ 11	
Civil penalty-Workplace Standard Division	$ 266	$ 34	
Total Other Administrative and General	$ 127,986	$ 16,559	$ -

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

Schedule C-1 - Management Services*

Name of Facility Crestfield Rehabilitation Center	License No. 2344	Report for Year Ended 9/30/2020	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 #
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032		Contract Attached to a Prior Year	See Below
Allocation of the above		Admin/Gen 66%	Page 28
		Indirect 16%	Page 29
		Direct 18%	Page 29
Athena Health Care Assoc., Inc. 135 South Road Farmington, CT 06032		Admin/Gen - Other Exp	Page 28

*** 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. 9/2018

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
Crestfield Rehabilitation Center	2344	9/30/2020	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	302,745	268,062	34,683	
2. Non-Food Supplies	$	19,568	17,326	2,242	
3. Other (*Specify*)_____ Dishes/supplies	$	2,487	2,202	285	
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)	$	324,800	287,590	37,210	

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

G.	Is cost of employee meals included in 2D?	◉ 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. $4,292
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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-19 Rev. 9/2018

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
Crestfield Rehabilitation Center	2344	9/30/2020	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. $	17,425	15,429	1,996	
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	1,600	1,417	183	
c. Other (*Specify*) Supplies	$	6,199	5,489	710	
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	25,224	22,335	2,889	

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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-20 Rev. 9/2018

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
Crestfield Rehabilitation Center	2344	9/30/2020	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.	$				
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)		$				
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Procare LTC		$	231,200	231,200		
b. Medicine Cabinet Drugs		$	13,590	12,033	1,557	
c. Medical and Therapeutic Supplies		$	312,264	276,490	35,774	
d. Ambulance/Limousine***		$	18,751	18,751		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	737	653	84	
f. X-rays and Related Radiological Procedures***		$	17,341	17,341		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	399	399		
i. Recreation		$	3,775	3,342	433	
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	127,471	114,203	13,268	
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	725,528	674,412	51,116	

* 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)
Medical Equipment Rental-Medicaid	$ 24,762	$ 3,204	
Physical therapy Supplies	$ 11,670		
Oxygen Concentrator Rentals	$ 21,149	$ 2,736	
Cable TV fees	$ 16,737	$ 2,166	
Medical Equipment rentals	$ 35,100	$ 4,542	
IV Therapy - other	$ 4,785	$ 620	
Total Other Resident Care	$ 114,203	$ 13,268	$ -

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
Crestfield Rehabilitation Center	2344	9/30/2020	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
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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).

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Groundskeeping	$ 22,782	$ 2,948	
Rubbish Removal	$ 29,696	$ 3,842	
Snow removal	$ 15,137	$ 1,959	
Supplies	$ 23,016	$ 2,978	
Total Other Repairs and Maintenance	$ 90,631	$ 11,727	$ -

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
Crestfield Rehabilitation Center	2344	9/30/2020			22 | 37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	109,906	97,315	12,591	
b. Heat	$	53,324	47,215	6,109	
c. Light & Power	$	82,773	73,290	9,483	
d. Water	$	33,368	29,545	3,823	
e. Equipment Lease (*Provide detail on page 6*)	$	7,900	6,995	905	
f. Other (*itemize*)	$	102,358	90,631	11,727	
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	389,629	344,991	44,638	
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$				
d. Movable Equipment	$	21,031	12,890	8,141	
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	21,031	12,890	8,141	
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	2,467	1,512	955	
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	2,467	1,512	955	
9. Rental payments on leased real property less real estate taxes included in item 10b	$	541,999	332,193	209,806	
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	52,102	31,933	20,169	
c. Personal property taxes	$	16,742	10,261	6,481	
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	634,341	388,789	245,552	

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

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
Crestfield Rehabilitation Center	2344	9/30/2020	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								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	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			9	2019	127,479		127,479	9,459	S/L	Various	18,917	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					39,944						2,114	
D-3. Subtotal												21,031
E. ***Total Depreciation***												21,031

Crestfield Moveable Equipment Carryforward Schedule

Cost Year		2019 property only review	Totals
	Original Disallow Adjustment		
	Cost	$ 50,000	
	Term	10	
2019	Deprec	$ 2,500	$ 2,500
2019	Book Value	$ 47,500	$ 47,500
2020	Deprec	$ 5,000	$ 5,000
2020	Book Value	$ 42,500	$ 42,500
2021	Deprec	$ 5,000	$ 5,000
2021	Book Value	$ 37,500	$ 37,500
2022	Deprec	$ 5,000	$ 5,000
2022	Book Value	$ 32,500	$ 32,500
2020	Deprec	$ 5,000	$ 5,000
2020	Book Value	$ 27,500	$ 27,500
2021	Deprec	$ 5,000	$ 5,000
2021	Book Value	$ 22,500	$ 22,500
2022	Deprec	$ 5,000	$ 5,000
2022	Book Value	$ 17,500	$ 17,500
2023	Deprec	$ 5,000	$ 5,000
2023	Book Value	$ 12,500	$ 12,500
2024	Deprec	5000	$ 5,000
2024	Book Value	$ 7,500	$ 7,500
2025	Deprec	5000	$ 5,000
2025	Book Value	$ 2,500	$ 2,500
2026	Deprec	2500	$ 2,500
2026	Book Value	$ -	$ -

Schedule of Land Improvements Acquired during this report period

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 period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Building Improvement		$ -		$ -	*
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 Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
2/29/2020	Milk cooler	$ 4,278	10	$ 214	
3/31/2020	Unimac washer	$ 16,075	10	$ 804	
3/31/2020	Thermal printer	2357	10	118	
4/30/2020	Cart	872	10	44	
5/31/2020	Resident Furniture	2661	15	89	
5/31/2020	water pump	7407	10	370	
5/31/2020	Circulator Pump	4916	10	245	
7/31/2020	Tablets	1378	3	230	
Total additions for Movable Equipmen		$ 39,944		$ 2,114	*
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 Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
11/30/2019	HVAC plumbing	$ 4,708	20	$ 118	
2/29/2020	Walk-in Cooler motor	$ 4,015	15	$ 134	
Total additions for Leasehold Improvemer		$ 8,723		$ 252	*
Deletions:					
Total deletions for Leasehold Improvemer		$ -		$ -	**

***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
Crestfield Rehabilitation Center	2344	9/30/2020	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	9	2019	Various	30,837	1,108	S/L	Variou	2,215	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				8,723				252	
C-4. Subtotal									2,467
D. ***Total Amortization***									2,467

* 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
Crestfield Rehabilitation Center	2344	9/30/2020	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	12/18/18
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	155
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)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year	6.03%			
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed	5,750,000			
f. Principal balance outstanding as of _____	5,750,000			
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
Crestfield Rehabilitation Center	2344	9/30/2020	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
Crestfield Rehabilitation Center	2344	9/30/2020	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*) $	2,257	1,383	874	
A. Item: Computer equipment / Rate: 8.50% / Amount				
Lender: Hewlett Packard				
Address of Lender: 200 Connell DriveBerkely Heights, NJ 07922				
B. Item / Rate / Amount				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $	2,257	1,383	874	
12. D. Other Interest Expense (*Specify*) $	14,720	9,021	5,699	
Vendor Interest				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	16,977	10,404	6,573	
14. Insurance				
a. Insurance on Property (buildings only) $	88,195	54,055	34,140	
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $				
2. Fire and Extended Coverage $				
3. Other (*Specify*) $				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	88,195	54,055	34,140	
15. ***Total All Expenditures (A-13 thru C-14)*** $	11,892,944	10,495,336	1,397,608	

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-28 Rev. 9/2018

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Crestfield Rehabilitation Center	2344	9/30/2020	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.	10	A12g	Occupational Therapy $	229,160	229,160		
4.			Other - See attached Schedule $	2,713	2,402	311	
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians ** $	6,321	6,321		
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	56,216	56,216		
10.	15	1d &	Accounting $	30,695	27,165	3,530	
10a.			Legal $	4,487	3,971	516	
11.			Telephone $				
12.	15	1h2	Cellular Telephone $	208	184	24	
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.	16	l3	Gifts, flowers and coffee shops $	12,424	11,001	1,423	
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.	16	m2 &	Unallowable Advertising * $	3,613	3,199	414	
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $	(156,404)	(156,404)		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	42,759	37,861	4,898	
Page 18 - Dietary Expenditures							
24.	18	2a1	Meals to employees, guests and others who are not residents $	4,292	3,800	492	
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) $	236,484	224,876	11,608	

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

** Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	12m	Community Coordinator:Salary & Benefits	$ 2,402	$ 311	
Total Other Salaries Adjustment			$ 2,402	$ 311	$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Bank Charges	$ 37,595	$ 4,864	
16	m13	Civil Penealty- Wage and Workplace Standards Division	$ 266	$ 34	
Total Other A&G Adjustments			$ 37,861	$ 4,898	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-29 Rev. 9/2018

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

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2020	29	37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	236,484	224,876	11,608	
Page 20 - Resident Care Supplies***								
27.	20	5a1 &	Prescription Drugs	$	231,200	231,200		
28.	20	5d	Ambulance/Limousine	$	18,751	18,751		
29.	20	5f	X-rays, etc	$	17,341	17,341		
30.	20	5h	Laboratory	$	399	399		
31.	20	5c	Medical Supplies	$	19,380	17,160	2,220	
32.	20	5e	Oxygen (non emergency)	$	737	653	84	
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	57,067	50,529	6,538	
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$	5,000	3,050	1,950	
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.			Other - Indirect	$	15,303	13,550	1,753	
43.			Interest Income on Account Rec.	$	152	135	17	
44.			Other - Miscellaneous Administrative	$				
45.			Management Fees Direct	$	(42,656)	(42,656)		
46.			Management Fees Indirect	$	(37,916)	(37,916)		
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)***			$	521,242	497,072	24,170	

*** 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	(Specify)
20	5j	Medical Equipment Rental	$ 35,100	$ 4,542	
20	5b	Ebox	$ 10,643	$ 1,377	
20	5j	IV Therapy Other	$ 4,786	$ 619	
Total Other Ancillary Costs			$ 50,529	$ 6,538	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7f	Moveable Equipment Depr Carryforward AJE	$ 3,050	$ 1,950	
Total Excess Movable Equipment Depreciation			$ 3,050	$ 1,950	$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Cable expense	$ 13,550	$ 1,753	
Total Other Adjustments			$ 13,550	$ 1,753	$ -

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct 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
Crestfield Rehabilitation Center	2344	9/30/2020	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	9,575,643	9,567,583	8,060	
b. Medicaid Room and Board Contractual Allowance **	$	(3,379,800)	(3,377,484)	(2,316)	
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,330,473	901,385	429,088	
b. Medicare Room and Board Contractual Allowance **	$	594,405	325,136	269,269	
4. a. Private-Pay Residents and Other	$	2,523,988	1,524,073	999,915	
b. Private-Pay Room and Board Contractual Allowance **	$	(50,221)	(66,606)	16,385	
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	162,895	162,895		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(162,855)	(162,855)		
c. Prescription Drugs - Non-Medicare	$	159,353	159,353		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(159,353)	(159,353)		
2. a. Medical Supplies - Medicare	$	3,880	3,880		
b. Medical Supplies - Medicare Contractual Allowance **	$	(3,880)	(3,880)		
c. Medical Supplies - Non-Medicare	$	280	280		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(280)	(280)		
3. a. Physical Therapy - Medicare	$	382,352	382,352		
b. Physical Therapy - Medicare Contractual Allowance **	$	(320,892)	(320,892)		
c. Physical Therapy - Non-Medicare	$	324,050	324,050		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(324,050)	(324,050)		
4. a. Speech Therapy - Medicare	$	194,150	194,150		
b. Speech Therapy - Medicare Contractual Allowance **	$	(169,527)	(169,527)		
c. Speech Therapy - Non-Medicare	$	158,525	158,525		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(158,525)	(158,525)		
5. a. Occupational Therapy - Medicare	$	483,152	483,152		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(393,741)	(393,741)		
c. Occupational Therapy - Non-Medicare	$	331,800	331,800		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(331,800)	(331,800)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	326,960	326,960		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	11,096,982	9,376,581	1,720,401	
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)*	$	152	135	17	
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$				
V. Total Other Revenue (1 thru 8)	$	152	135	17	
VI. Total All Revenue (III +V)	$	11,097,134	9,376,716	1,720,418	

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
N/A	Misc Revenues from CRF Funds	$ 326,960		
Total Other Resident Revenue		$ 326,960	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
31, L A2	Interest on A/R	N/A	$ 135	$ 17	
Total Interest Income			$ 135	$ 17	$ -

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
Crestfield Rehabilitation Center	2344	9/30/2020	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 322,963
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,583,744
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ (949,787)
4 Inventories				$ 19,305
5. Prepaid Expenses				$ 140,701
a. Ppd Insurance		137,474		
b. Ppd Health Insurance		2,693		
c. Ppd personal property taxes		534		
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$ (303,562)
8. Other Current Assets (*itemize*)				$ 10,211
A/R exchange		10,211		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 823,575
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	39,560		$ 35,985
	Accum. Depreciation	3,575	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	124,924		$ 94,434
	Accum. Depreciation	30,490	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 42,500
Excludable Moveable Equipment		42,500		
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 172,919

* 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)			$ -

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
Crestfield Rehabilitation Center	2344	9/30/2020	32	37

Account				Amount
			Total Brought Forward:	$ 996,494
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)				$ 1,890,307
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*)				$ 271,225
Deposit - Utilities		4,855		
Project Development		266,370		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 2,161,532
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 3,158,026

* 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
Crestfield Rehabilitation Center	2344	9/30/2020	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 1,806,396
2. Notes Payable (*itemize*)				$ 13,228
Due From Related Party		591,929		
Line of Credit		(603,701)		
Notes Payable (itemize)		25,000		
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*)				$ 266,172
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 235,144
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*)				$ 465,219
Accd Operating Expenses	36,904			
Accd Sales & Use tax	170			
Due to Medicaid-Provider Tax	425,256			
Accd Health Insurance	2,889	See Schedule		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 2,786,159

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

(Carry Total forward to next page)

Crestfield Rahab

accrued expenses

9/30/2020

	$	5,505.73	ibnr
9/30/2020	$	948.23	Utilities - gas
	$	1,823.28	Utilities - gas
9/30/2020	$	12,500.00	Medical Director
9/30/2020	$	2,230.78	Rubbish removal
9/30/2020	$	113.40	Oxygen Equipment rental
9/30/2020	$	79.20	Oxygen Equipment rental
9/30/2020	$	113.40	Oxygen Equipment rental
9/30/2020	$	79.20	Oxygen Equipment rental
9/30/2020	$	246.30	Oxygen Equipment rental
9/30/2020	$	370.68	Oxygen Equipment rental
9/30/2020	$	79.20	Oxygen Equipment rental
9/30/2020	$	562.00	PS Maintenance
9/30/2020	$	(203.10)	Nursing supplies
9/30/2020	$	277.66	business promotion
9/30/2020	$	12,178.46	Pharmacy
	$	36,904.42	

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
Crestfield Rehabilitation Center	2344	9/30/2020	34	37

Account	Amount
Total Brought Forward:	2,786,159
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$ 19,534

Name of Lender	Purpose	Amount	Date Due
HP Lease	Computer equipment		

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$ 1,305,892

Name and Address of Lender	Amount	Loan Date
	1,305,892	none

4. Other Long-Term Liabilities (*itemize*)	$
See Schedule	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 1,325,426
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 4,111,585

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
Crestfield Rehabilitation Center	2344	9/30/2020	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				$	
	4. Treasury Stock				$	
	5. Cumulated Earnings				$	(101,972)
	6. Gain or Loss for Period	10/1/2019	thru	9/30/2020	$	(851,587)
	7. Total Net Worth				$	(953,559)
C.	***Total Reserves and Net Worth***				$	(953,559)
D.	***Total Liabilities, Reserves, and Net Worth***				$	3,158,026

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
Crestfield Rehabilitation Center	2344	9/30/2020	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2019			$ 46,930
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 11,097,134
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 11,948,721
D.	Net Income or Deficit			$ (851,587)
E.	Balance			$ (804,657)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Health Insurance adjmt - IBNR			(148,902)
	2. Other (*itemize*)			
F-3.	Total Additions			$ (148,902)
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***	09/30/20		$ (953,559)

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
Crestfield Rehabilitation Center	2344	9/30/2020	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
Athena Health Care Associates, Inc

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

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

Contact Email Address
lrinaldi@athenahealthcare.com