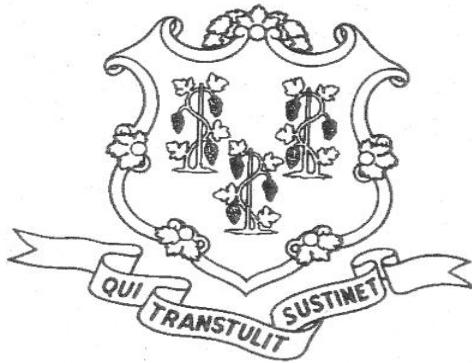


# State of Connecticut



# Annual Report of Long-Term Care Facility

## Cost Year 2022

Name of Facility (as licensed) New Horizons Inc. d/b/a Cherry Brook HCC		
Address (No. & Street, City, State, Zip Code) 102 Dyer Avenue, Canton, CT 06019		
Type of Facility		
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS)	<input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2021	Report for Year Ending 9/30/2022	

License Numbers:	CCNH 2125C	RHNS	(Specify)	Medicare Provider 07-5396
------------------	---------------	------	-----------	------------------------------

Medicaid Provider Numbers:	CCNH 2125C	RHNS	ICF-IID
----------------------------	---------------	------	---------

## For Department Use Only

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

**General Information**

Name of Facility (as licensed) New Horizons Inc. d/b/a Cherry Brook HCC	License No. 2125C	Report for Year Ended 9/30/2022	Page 1	of 37
--	----------------------	------------------------------------	-----------	----------

**Administrator's/Owner's Certification**

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for New Horizons Inc. d/b/a Cherry Brook HCC [facility name], for the cost report period beginning October 1, 2021 and ending September 30, 2022, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)	Date	Signed (Owner)	Date	
Printed Name (Administrator) John Zazzaro		Printed Name (Owner) Carol Fitzgerald		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	
Address of Notary Public				

(Notary Seal)

# Table of Contents

General Information - Administrator's/Owner's Certification	1
General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
General Information and Questionnaire - Type of Facility - Organization Structure	2
General Information and Questionnaire - Partners/Members	3
General Information and Questionnaire - Corporate Owners	3A
General Information and Questionnaire - Individual Proprietorship	3B
General Information and Questionnaire - Related Parties	4
General Information and Questionnaire - Basis for Allocation of Costs	5
General Information and Questionnaire - Leases	6
General Information and Questionnaire - Accounting Basis	7
Schedule of Resident Statistics	8
Schedule of Resident Statistics (Cont'd)	9
<b>A. Report of Expenditures - Salaries &amp; Wages</b>	<b>10</b>
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
<b>B. Report of Expenditures - Professional Fees</b>	<b>13</b>
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
<b>C. Expenditures Other than Salaries - Administrative and General</b>	<b>15</b>
C. Expenditures Other than Salaries (Cont'd) - Administrative and General	16
Schedule C-1 - Management Services	17
C. Expenditures Other than Salaries (Cont'd) - Dietary	18
C. Expenditures Other than Salaries (Cont'd) - Laundry	19
C. Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
Depreciation Schedule	23
Amortization Schedule	24
C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C. Expenditures Other than Salaries (Cont'd) - Interest	26
C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D. Adjustments to Statement of Expenditures	28
D. Adjustments to Statement of Expenditures (Cont'd)	29
<b>F. Statement of Revenue</b>	<b>30</b>
<b>G. Balance Sheet</b>	<b>31</b>
G. Balance Sheet (Cont'd)	32
G. Balance Sheet (Cont'd)	33
G. Balance Sheet (Cont'd)	34
G. Balance Sheet (Cont'd) - Reserves and Net Worth	35
<b>H. Changes in Total Net Worth</b>	<b>36</b>
<b>I. Preparer's/Reviewer's Certification</b>	<b>37</b>

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

<b>Data Required for Real Wage Adjustment</b>		Page 1A	of 37
Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC	Period Covered:	From 10/1/2021	To 9/30/2022
Address of Facility 102 Dyer Avenue, Canton, CT 06019			
Report Prepared By Athena Health Care Associates Inc	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. <b>Total Wages Paid</b>	\$		
7. Total salaries paid	\$		
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$		

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

**General Information and Questionnaire**  
**Type of Facility - Organization Structure**

Phone No. of Facility	Report for Year Ended	Page	of
860-693-7777	9/30/2022	2	37

Name of Facility (as shown on license) New Horizons Inc. d/b/a Cherry Brook HCC		Address (No. & Street, City, State, Zip) 102 Dyer Avenue, Canton, CT 06019		
License Numbers:	CCNH 2125C	RHNS	(Specify)	Medicare Provider No. 07-5396
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input checked="" type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," explain fully.

**Administrator**

Name of Administrator John Zazzaro	Nursing Home Administrator's License No.: 001734
---------------------------------------	---

Other Operators/Owners who are assistant administrators (full or part time) of this facility.	
Name N/A	License No.:

## **General Information and Questionnaire Partners/Members**

# **General Information and Questionnaire**

## **Corporate Owners**

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

Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC	License No. 2125C	Report for Year Ended 9/30/2022	Page 3B	of 37
--	----------------------	------------------------------------	------------	----------

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

Owner(s) of Facility

N/A

## General Information and Questionnaire

### Related Parties\*

Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC	License No. 2125C	Report for Year Ended 9/30/2022	Page 4	of 37				
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input type="radio"/> Yes <input checked="" type="radio"/> No			If "Yes," provide the Name/Address and complete the information on Page 11 of the report.					
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? <input checked="" type="radio"/> Yes <input type="radio"/> No			If "Yes," provide the following information:					
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party	
		Yes	No	%**				Description of Goods/Services Provided
New Horizons Inc	37 Bliss Memorial Rd, Collinsville, CT 06085	<input type="radio"/>	<input checked="" type="radio"/>		Pension, Maintenance, legal,accounting,heal	P 15, L1a7, P22, L6a, P	456,866	256,866
New Horizons Inc	37 Bliss Memorial Rd, Collinsville, CT 06085	<input type="radio"/>	<input checked="" type="radio"/>		Cherry Brook participates in a common 401	Pg 15 Ln 1a7		
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

\* Use additional sheets if necessary.

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

## **General Information and Questionnaire**

### **Basis for Allocation of Costs**

Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC	License No. 2125C	Report for Year Ended 9/30/2022	Page 5	of 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 ( <i>See listing page 13</i> )
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

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

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

Not Applicable

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

Not Applicable

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

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

outpatient services

# 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.

## Is a Mileage Log Book Maintained for All Leased Vehicles ?

○ Yes

○ No

Total \*\*\*

12,883

\* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

\*\* Attach copies of newly acquired leases.

\*\*\* Amount should agree to Page 22, Line 6e.

# **General Information and Questionnaire**

## **Accounting Basis**

Name of Facility New Horizons Inc. d/b/a Cherry Br	License No. 2125C	Report for Year Ended 9/30/2022	Page 7	of 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?

## **Independent Accounting Firm**

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 CohnReznick LLP	Hartford, CT
2 Marcum LLP	555 Long Wharf DR, New Haven, CT 06511
3	
4	

**Services Provided by This Firm (*describe fully*)**

1	Audit & Year End Financials	\$	39,567
2	Medicare Cost report	\$	2,750
3		\$	
4		\$	
		Charge for Services Provided	
		\$	42,317

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

Yes  No

## Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Pilicy & Ryan, PC	860-274-0018
2 Morrison Mahoney LLP	617-439-7500
3 Melick & Porter LLP	617-523-6200
4	
5	

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

1 385 Main Street, PO Box 760, Watertown, CT 06795  
2 250 Summer St, Boston MA  
3 One Liberty Square, Boston MA  
4  
5

**Services Provided by This Firm (*describe fully*)**

1	Collections:Disallowed	\$	368
2	COVID/Osha issues:Disallowed	\$	148
3	Employee Settlement: Disallowed	\$	13,958
4		\$	
5		\$	

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

Yes  No

## Schedule of Resident Statistics

Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC			License No. 2125C			Report for Year Ended 9/30/2022				Page 8 of 37		
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity					100	100						
A. On last day of PREVIOUS report period	100	100										
B. On last day of THIS report period	100	100							100	100		
2. Number of Residents					81	81						
A. As of midnight of PREVIOUS report period	81	81										
B. As of midnight of THIS report period	85	85							85	85		
3. Total Number of Days Care Provided During Period					3,660	3,660						
A. Medicare	4,556	4,556							896	896		
B. Medicaid (Conn.)	21,537	21,537			15,756	15,756			5,781	5,781		
C. Medicaid (other states)												
D. Private Pay	3,649	3,649			2,702	2,702			947	947		
E. State SSI for RCH												
F. Other (Specify) Managed care	131	131			127	127			4	4		
G. Total Care Days During Period (3A thru F)	29,873	29,873			22,245	22,245			7,628	7,628		
Total Number of Days Not Included in Figures in 3G												
4. for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	42	42			8	8			34	34		
B. Other Bed Reserve Days												
<b>5. Total Resident Days (3G + 4A + 4B)</b>	<b>29,915</b>	<b>29,915</b>			<b>22,253</b>	<b>22,253</b>			<b>7,662</b>	<b>7,662</b>		

## Schedule of Resident Statistics (Cont'd)

Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC	License No. 2125C	Report for Year Ended 9/30/2022	Page 9	of 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			CCNH	RHNS	(Specify)		
				(1)	(2)	(3)	(1)	(2)	(3)					

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

	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	5	64		14			2	
Per Diem Rate								
a. One bed rm.	558.00	293.74		596.00			390.00	
b. Two bed rms.	558.00	294.00		584.00			390.00	
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B		TOTAL	CCNH	RHNS	(Specify)
		7,622	7,622		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments		170	170		
2. Restorative Treatments					
C. Other		10,309	10,309		
D. <b>Total Physical Therapy Treatments</b>		18,101	18,101		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B		737	737		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments		48	48		
2. Restorative Treatments					
C. Other		1,297	1,297		
D. <b>Total Speech Therapy Treatments</b>		2,082	2,082		

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B		4,406	4,406		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments		195	195		
2. Restorative Treatments					
C. Other		10,045	10,045		
D. <b>Total Occupational Therapy Treatments</b>		14,646	14,646		

## Report of Expenditures - Salaries &amp; Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		2125C	9/30/2022		10
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes		<input type="radio"/> No	
		Total Cost and Hours			
Item		CCNH	Hours	RHNS	Hours
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	175,590	2,045			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	242,706	10,104			
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor	69,648	1,990			
c. Dietary Workers	427,783	23,783			
6. Housekeeping Service					
a. Head Housekeeper	64,851	2,389			
b. Other Housekeeping Workers	187,593	10,735			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	68,288	2,145			
b. Other Maintenance Workers	46,710	2,211			
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers	95,632	5,798			
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	179,798	3,063			
b. RN					
1. Direct Care	687,259	13,610			
2. Administrative**	497,063	14,180			
c. LPN					
1. Direct Care	1,003,434	24,226			
2. Administrative**					
d. Aides and Attendants	1,127,637	46,861			
e. Physical Therapists	521,898	13,431			
f. Speech Therapists	77,779	1,712			
g. Occupational Therapists	281,037	6,978			
h. Recreation Workers	118,941	5,603			
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	188,513	5,329			
n. Marketing					
o. Other (Specify) See Attached Schedule					
<i>A-13. Total Salary Expenditures</i>	6,062,160	196,193			

\* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

\*\* Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and

Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

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

**Schedule of Other Salaries and Wages (Page 10)**

**Schedule of Other Fees (Page 13)**

State of Connecticut

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

CSP-11 Rev. 10/2005

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

Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC			License No. 2125C		Report for Year Ended 9/30/2022			Page 11	of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section I - Operators/Owners</b>										
NA										
<b>Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).</b>										
NA										

\* 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 12 of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section III - Administrators***</b>										
Danoald Davanzo - Severance	16,559			Health and life ins, payroll taxes			A2			
John Zazzarro (10/1/21-9/30/22)	159,031			Health and life ins, payroll taxes	day to day operations of facility	2,045	A2			
<b>Section IV - Assistant Administrators</b>										

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

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

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

**B. Report of Expenditures - Professional Fees**

Name of Facility	License No.	Report for Year Ended		Page	of
	2125C	9/30/2022		13	37
	Total Cost and Hours				
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary</b> (For all such services complete Schedule B1)					
1. Dietitian	15,251	436			
2. Dentist	2,400				
3. Pharmacist	10,063	12			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	46,800	179			
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**	425				
d. Administrative Services facility					
1. Infection Control Committee (Quarterly meetings)					
2. Pharmaceutical Committee (Quarterly meetings)					
3. Staff Development Committee (Once annually)					
e. Other (Specify) Medical Staff Meetings	1,800	18			
9. Speech Therapist					
a. Resident Care	3,960	11			
b. Other					
10. Occupational Therapist					
a. Resident Care					
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	33,748	363			
2. Administrative***					
b. LPN					
1. Direct Care	398,274	5,443			
2. Administrative***					
c. Aides	495,346	12,208			
d. Other					
12. Other (Specify) See Attached Schedule					
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	1,008,067	18,670			

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

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

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

## Report of Expenditures

## Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis\*

Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC	License No. 2125C	Report for Year Ended 9/30/2022		Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Michele Lux, 9 Feetwood Drive, Plainville, CT 06062	Dietician	<input type="radio"/>	<input checked="" type="radio"/>		
The Nurse Network, 653 Main street, Plainville, CT	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Gary Miller MD, 61 Bradley St, Bristol, CT 06010	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Norton & Associates, 34 Elm Street, Cohasset, MA	Social Service Fill-in position and nurse pool	<input type="radio"/>	<input checked="" type="radio"/>		
Amor Lomibao, 71 Spenser St, Winsted, CT 06098	Sub-acute Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Favorite health care staffing, PO Box 26225, Overland Park, KS 66225	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>		
SDX Dysphagia Experts, 21 Waterville Rd., Avon, CT 06001	Speech Therapy services	<input type="radio"/>	<input checked="" type="radio"/>		
MASSTEX, 3 Electronics Ave, Danvers, MA	Speech Therapy Services	<input type="radio"/>	<input checked="" type="radio"/>		
Vista Behavioral Health, LLC 152 Simsbury Rd Bldg 9 Avon, CT 06001	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>		
ValueRx Pharmacy Services, 54 Tuttle Place, Middletown, CT 06457	Pharmacy Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
Starling Physicians 2110 Silas Deane Highway, Rocky Hill, CT	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
Clipboard Health, 340 S Lemon Ave, Walnut, CA 91789	nurse pool	<input type="radio"/>	<input checked="" type="radio"/>		
Delta T Group PO Box 884, Bryn Mawr, PA 19010	nurse pool	<input type="radio"/>	<input checked="" type="radio"/>		
Worldwide Staffing, 2222 Sedwick Road, Durham, NC 27713	nurse pool	<input type="radio"/>	<input checked="" type="radio"/>		
Prime Time Healthcare, 15380 Weir st, Omaha, NE 68137	nurse pool	<input type="radio"/>	<input checked="" type="radio"/>		
Bristol Hospital, 41 Brewster Rd, Bristol, CT	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
Health Drive Audiology, 100 Crossing BLVD, Suite 300, Framingham, MA	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
Health Drive EyeCare, 100 Crossing BLVD, Suite 300, Framingham, MA	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
Cardiologist Associates of Greater Waterbury, PO Box 15821, Belfast, ME 04915-4053	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Isaac Bosco DMD, 191 Albany Tpke, Canton, CT	Dental consulting	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		

\* Use additional sheets if necessary.

\*\* Refer to Page 4 for definition of related.

**C. Expenditures Other Than Salaries - Administrative and General**

Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC	License No. 2125C	Report for Year Ended 9/30/2022		Page 15	of 37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$	122,036	122,036		
2. Disability Insurance	\$				
3. Unemployment Insurance	\$	80,709	80,709		
4. Social Security (F.I.C.A.)	\$	416,456	416,456		
5. Health Insurance	\$	608,597	608,597		
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$	98,558	98,558		
8. Uniform Allowance	\$				
9. Other ( <i>Specify</i> ) See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$	24,446	24,446		
d. Accounting and Auditing	\$	42,317	42,317		
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$	14,474	14,474		
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$				
g. Office Supplies	\$	61,589	61,589		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	26,035	26,035		
2. Cellular Phones	\$	1,935	1,935		
i. Appraisal ( <i>Specify purpose and attach copy</i> )*	\$				
j. Corporation Business Taxes ( <i>franchise tax</i> )	\$				
k. Other Taxes ( <i>Not related to property - See Page 22</i> )					
1. Income*	\$				
2. Other ( <i>Specify</i> ) See Attached Schedule	\$				
3. Resident Day User Fee	\$	533,950	533,950		
<b>Subtotal</b>	\$	2,031,102	2,031,102		

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

(Carry Subtotals forward to next page)

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

Attachment Page 15

**Schedule of Other Employee Benefits**

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

---

**Schedule of Other Taxes**

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

---

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

Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC	License No. 2125C	Report for Year Ended 9/30/2022	Page 16	of 37
Item	Total	CCNH	RHNS	(Specify)
<b><i>Subtotals Brought Forward:</i></b>	2,031,102	2,031,102		
I. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$			
3. Gifts to Staff and Residents	\$	12,141	12,141	
4. Employee Travel	\$	464	464	
5. Education Expenses Related to Seminars and Conventions	\$	2,127	2,127	
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$			
7. Other ( <i>Specify</i> ) See Attached Schedule	\$			
m. Other Administrative and General Expenses				
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$	26,071	26,071	
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$			
3. Advertising Other ( <i>Specify</i> )**** See Attached Schedule	\$	17,967	17,967	
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	\$	3,159	3,159	
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	11,231	11,231	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$	175	175	
10. Contributions*** See Attached Schedule	\$			
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$			
12. Administrative Management Services**	\$	171,600	171,600	
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	275,174	275,174	
<b><i>C-14 Total Administrative &amp; General Expenditures</i></b>	\$	2,551,211	2,551,211	

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

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
Promotional	\$ 17,967		
<b>Total Other Advertising</b>	\$ 17,967	\$ -	\$ -

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
Promotional			
Leading Age of CT	\$ 10,881		
CAHCF	\$ 350		
<b>Total Dues</b>	\$ 11,231	\$ -	\$ -

**Schedule of Contributions**

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

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
ST of CT - Annual license renewal	\$ 940		
bank charges	\$ 9,271		
Payroll processing fees	\$ 12,009		
employee physicals and background checks	\$ 1,865		
Management Fee - New Horizons Inc	\$ 200,000		
data processing	\$ 51,089		
<b>Total Other Administrative and General</b>	\$ 275,174	\$ -	\$ -

**Schedule C-1 - Management Services\***

Name of Facility New Horizons Inc. d/b/a Cherry Brook HC	License No. 2125C	Report for Year Ended 9/30/2022	Page of 17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Athena Health Care Assoc., Inc, 135 South Rd, Farmington, CT	223,200	contract attached to prior year	see Below
Allocation of the above	ct, \$40,176 Direct	A & G - 66%, Indirect - 16%, Direct - 18%	Pg 16, Line 12, Pg 20, L
Athena Health Care Assoc., Inc, 135 South Rd, Farmington, CT	24,288	Admin/Gen - Other Expense	Pg 16, Line 12
New Horizons Inc, 37 Bliss Memorial Rd, Unionville, CT	200,000	Administrative fee	Pg 16, Line 13

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

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

Name of Facility	License No.	Report for Year Ended		Page of
	2125C	9/30/2022		18   37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 268,837	268,837		
2. Non-Food Supplies	\$ 33,685	33,685		
3. Other (Specify) _____ Dishes & Utensils	\$ 479	479		
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	\$			
c. Other (Specify) _____	\$			
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 303,001</b>	<b>303,001</b>		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	246	246		
G. Is cost of employee meals included in 2D? <input checked="" type="radio"/> Yes <input type="radio"/> No				
H. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
K. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC	License No. 2125C	Report for Year Ended 9/30/2022	Page 19	of 37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$			
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. \$	14,591	14,591	
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$			
c. Other ( <i>Specify</i> ) supplies	\$	7,709	7,709	
<b>3D. Total Laundry Expenditures (3a + b + c )</b>	<b>\$</b>	<b>22,300</b>	<b>22,300</b>	
3E. Laundry Questionnaire				
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
H. Where is the revenue received reported in the Cost Report?			(Page/Line Item)	
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
K. Where is the revenue received reported in the Cost Report?			(Page/Line Item)	

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

All allocations should add to total recorded in 3D.

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2022		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 43,127	43,127		
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )					
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	Sq. Ft. Serviced by Personnel				
	Amt.	\$ 84,660	84,660		
C. Other ( <i>Specify</i> )	\$				
<b>4D. Total Housekeeping Expenditures (4a + b + c )</b>	\$	<b>127,787</b>	<b>127,787</b>		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Value RX	\$	208,727	208,727		
b. Medicine Cabinet Drugs	\$	13,899	13,899		
c. Medical and Therapeutic Supplies	\$	241,936	241,936		
d. Ambulance/Limousine***	\$	5,008	5,008		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	19,060	19,060		
f. X-rays and Related Radiological Procedures***	\$	17,539	17,539		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$	28,564	28,564		
i. Recreation	\$	18,946	18,946		
j. Direct Management Services*	\$	40,176	40,176		
k. Indirect Management Services*	\$	35,712	35,712		
l. Other ( <i>Specify</i> )**** See Attached Schedule	\$	89,973	89,973		
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>	\$	<b>719,540</b>	<b>719,540</b>		

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

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

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

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

## **Schedule of Other Resident Care**

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

Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC				License No. 2125C	Report for Year Ended 9/30/2022				Page of 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.***				Pg	Line
		Yes	No			CCNH	RHNS	(Specify)			
Riverside Nursery	Box 435, Collinsville, CT 06022	<input type="radio"/>	<input checked="" type="radio"/>		Groundskeeping, Snow Removal	40,345				22	6f
CWPM	P.O.Box 415, Plainville, CT	<input type="radio"/>	<input checked="" type="radio"/>		Rubbish Removal	22,487				22	6f
Athena Health Care Associates	135 South Road, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Management Services	247,488				17	
ADP	100 Corporate Drive, Windsor, CT	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Processing	12,009				16	m13
ValueRx Pharmacy Services	54 Tuttle Place, Middletown, CT 06457	<input type="radio"/>	<input checked="" type="radio"/>		Pharmacy Services	229,219				20	5a2
City Wide Facility Solutions	950 Watertown St, STE #7, West Newton, MA	<input type="radio"/>	<input checked="" type="radio"/>		P/S Housekeeping	68,604				20	4b
Primary Cleaning Inc	68 Bridge St, Suite 310, Suffield, CT 06078	<input type="radio"/>	<input checked="" type="radio"/>		P/S Housekeeping	16,056				20	4b
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								

\* List all contracted services over \$10,000. Use additional sheets if necessary.

\*\* Refer to Page 4 for definition of related.

\*\*\* Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC	License No. 2125C	Report for Year Ended 9/30/2022			Page 22   37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$	86,316	86,316		
b. Heat	\$	35,722	35,722		
c. Light & Power	\$	125,454	125,454		
d. Water	\$	49,198	49,198		
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$	12,883	12,883		
f. Other ( <i>itemize</i> )	\$	78,001	78,001		
See Attached Schedule					
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$	387,574	387,574		
7. Depreciation ( <i>complete schedule page 23*</i> )					
a. Land Improvements	\$	29,169	29,169		
b. Building & Building Improvements	\$	297,315	297,315		
c. Non-Movable Equipment	\$	5,474	5,474		
d. Movable Equipment	\$	51,739	51,739		
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$	383,697	383,697		
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )					
a. Organization Expense	\$				
b. Mortgage Expense	\$	18,150	18,150		
c. Leasehold Improvements	\$				
d. Other ( <i>Specify</i> )	\$				
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$	18,150	18,150		
9. Rental payments on leased real property less real estate taxes included in item 10b	\$				
10. Property Taxes					
a. Real estate taxes paid by owner	\$	19,930	19,930		
b. Real estate taxes paid by lessor	\$				
c. Personal property taxes	\$	4,296	4,296		
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$	426,073	426,073		

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

## **Schedule of Other Repairs and Maintenance**

## Depreciation Schedule

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

\*Ties to Page 23, Line A3

\*\*Ties to Page 23, Line A2

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

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

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

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

\*\*Ties to Page 23, Line C2

## Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life		Depreciation
		Movable Category				
<b>Additions:</b>						
various	see attached	Administrative	\$ 24,675	various	\$ 1,753	
various	see attached	Standard Resident	\$ 1,932	5	\$ 193	
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
<b>Total additions for Movable Equipment</b>			\$ 26,607		\$ 1,946	*
<b>Deletions:</b>						
<b>Total deletions for Movable Equipment</b>			\$ -		\$ -	**

\*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
<b>Additions:</b>					
<b>Total additions for Leasehold Improvement</b>		\$ -		\$ -	*
<b>Deletions:</b>					
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ -	**

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Amortization Schedule\***

Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC			License No. 2125C		Report for Year Ended 9/30/2022			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
<b>A-4. Subtotal</b>									
<b>B. Mortgage Expense</b>									
1. Finance Fees - CHEFA	9	1994	30 years	922,570	922,570	S/L			
2. Finance Fees - Farmington Bank	12	2014	10 years	127,951	127,951	S/L			
3. Finance Fees - ION Bank	6	2021	4 years	72,599		S/L		18,150	
<b>B-4. Subtotal</b>									18,150
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
<b>C-4. Subtotal</b>									
<b>D. Total Amortization</b>									18,150

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

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

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

Name of Facility New Horizons Inc. d/b/a Cherry Brook	License No. 2125C	Report for Year Ended 9/30/2022	Page 25	of 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	01/14/93			
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure	01/14/93			
5. Total Licensed Bed Capacity	100			
6. Square Footage				
7. Acquisition Cost				
a. Land	1,000,000			
b. Building	6,039,220			

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	fixed			
b. Date Mortgage Obtained	06/02/21			
c. Interest Rate for the Cost Year	299.00%			
d. Term of Mortgage (number of years)	4			
e. Amount of Principal Borrowed	1,625,000			
f. Principal balance outstanding as of	1,127,493			

Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page 26	of 37
Item		Total	CCNH	RHNS	(Specify)	
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage		\$ 40161	40,161			
Name of Lender	Rate					
ION Bank	2.99%					
Address of Lender						
PO Box 370Naugatuck, CT 06770						
2. Second Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
3. Third Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
4. Fourth Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount		\$				
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$ 40,161	40,161			

(Carry Subtotals forward to next page )

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

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page 27	of 37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:			40,161	40,161		
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)			\$	3,832	3,832	
Vendor interest						
13. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>			\$	43,993	43,993	
14. Insurance						
a. Insurance on Property (buildings only)			\$	156,710	156,710	
b. Insurance on Automobiles			\$			
c. Insurance other than Property (as specified above)						
1. Umbrella ( <i>Blanket Coverage</i> )			\$			
2. Fire and Extended Coverage			\$			
3. Other (Specify)			\$			
14d. <b>Total Insurance Expenditures (14a + b + c)</b>			\$	156,710	156,710	
15. <b>Total All Expenditures (A-13 thru C-14)</b>			\$	11,808,416	11,808,416	

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

Name of Facility			License No.	Report for Year Ended		Page of
Item No.	Page No.	Line No.		CCNH	RHNS	28   37
			Item Description	Total Amount of Decrease		
<b>Page 10 - Salaries and Wages</b>						
1.			Outpatient Service Costs	\$		
2.			Salaries not related to Resident Care	\$		
3.			Occupational Therapy	\$ 281,037	281,037	
4.			Other - See attached Schedule	\$ 32,176	32,176	
<b>Page 13 - Professional Fees</b>						
5.			Resident Care Physicians **	\$ 425	425	
6.			Occupational Therapy	\$		
7.			Other - See attached Schedule	\$		
<b>Pages 15 &amp; 16 - Administrative and General</b>						
8.			Discriminatory Benefits	\$		
9.			Bad Debts	\$ 24,446	24,446	
10.			Accounting	\$ 14,474	14,474	
10a.			Legal	\$		
11.			Telephone	\$		
12.			Cellular Telephone	\$ 495	495	
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$		
14.			Gifts, flowers and coffee shops	\$ 12,141	12,141	
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 *	\$ 17,967	17,967	
19.			Income Tax / Corporate Business Tax	\$		
20.			Fund Raising / Contributions	\$		
21.			Unallowable Management Fees	\$ 10,908	10,908	
22.			Barber and Beauty	\$		
23.			Other - See attached Schedule	\$ 209,522	209,522	
<b>Page 18 - Dietary Expenditures</b>						
24.			Meals to employees, guests and others who are not residents	\$ 729	729	
<b>Page 19 - Laundry Expenditures</b>						
25.			Laundry services to employees, guests and others who are not residents	\$		
<b>Page 20 - Housekeeping Expenditures</b>						
26.			Housekeeping services to employees, guests and others who are not residents	\$		
Subtotal (Items 1 - 26)			\$ 604,320	604,320		

\* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

**Schedule of Other Salaries Adjustment**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	A12M	Marketing Salaries & Benefits	\$ 32,176		
<b>Total Other Salaries Adjustment</b>			\$ 32,176	\$ -	\$ -

**Schedule of Fees Adjustments**

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

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M13	Bank Fees	\$ 9,271		
16	M13	Management fee - New Horizon	\$ 200,000		
various	various	outpatient therapy : A & G costs	\$ 251		
<b>Total Other A&amp;G Adjustments</b>			\$ 209,522	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended		Page	of
New Horizons Inc. d/b/a Cherry Brook HCC			2125C	9/30/2022		29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 604,320	604,320		
<b>Page 20 - Resident Care Supplies***</b>							
27.			Prescription Drugs	\$ 208,727	208,727		
28.			Ambulance/Limousine	\$ 5,008	5,008		
29.			X-rays, etc	\$ 17,539	17,539		
30.			Laboratory	\$ 28,564	28,564		
31.			Medical Supplies	\$ 19,481	19,481		
32.			Oxygen (non emergency)	\$ 19,060	19,060		
33.			Occupational Therapy	\$ 593	593		
34.			Other - See Attached Schedule	\$ 19,742	19,742		
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 11,445	11,445		
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$ 1,432	1,432		
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$ 18,218	18,218		
43.			Interest Income on Account Rec.	\$ 1,638	1,638		
44.			Other - Miscellaneous Administrative	\$ 32,155	32,155		
45.			Management Fees Direct	\$ 2,975	2,975		
46.			Management Fees Indirect	\$ 2,644	2,644		
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$ 30,888	30,888		
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 1,024,429	1,024,429		

\*\*\* Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

### **Schedule of Other Ancillary Costs**

## **Schedule of Excess Movable Equipment Depreciation**

### Schedule of Other Property Adjustments

## **Schedule of Other - Indirect Adjustments**

Attachment Page 29

### **Schedule of Other - Miscellaneous Administrative Adjustments**

### **Schedule of Other - Direct Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Adjustments</b>			\$ -	\$ -	\$ -

## **Schedule of Unallowable Building Interest**

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page 30   37
Item		Total	CCNH	RHNS	(Specify)
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 12,485,676	12,485,676			
b. Medicaid Room and Board Contractual Allowance **	\$ (6,077,114)	(6,077,114)			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 1,488,895	1,488,895			
b. Medicare Room and Board Contractual Allowance **	\$ 178,726	178,726			
4. a. Private-Pay Residents and Other	\$ 3,269,432	3,269,432			
b. Private-Pay Room and Board Contractual Allowance **	\$ (294,857)	(294,857)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 37,677	37,677			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (33,827)	(33,827)			
c. Prescription Drugs - Non-Medicare	\$ 42,341	42,341			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (42,341)	(42,341)			
2. a. Medical Supplies - Medicare	\$ 3,288	3,288			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (3,288)	(3,288)			
c. Medical Supplies - Non-Medicare	\$ 5,893	5,893			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (5,893)	(5,893)			
3. a. Physical Therapy - Medicare	\$ 709,455	709,455			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (484,524)	(484,524)			
c. Physical Therapy - Non-Medicare	\$ 264,250	264,250			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (264,250)	(264,250)			
4. a. Speech Therapy - Medicare	\$ 146,735	146,735			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (108,439)	(108,439)			
c. Speech Therapy - Non-Medicare	\$ 61,600	61,600			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (61,600)	(61,600)			
5. a. Occupational Therapy - Medicare	\$ 541,427	541,427			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (403,452)	(403,452)			
c. Occupational Therapy - Non-Medicare	\$ 253,895	253,895			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (253,895)	(253,895)			
6. a. Other ( <i>Specify</i> ) - Medicare	\$				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 394,459	394,459			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 11,850,269	11,850,269			
<b>IV. Other Revenue*</b>					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income ( <i>Specify</i> )	\$ 2,110	2,110			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 43,226	43,226			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 45,336	45,336			
<b>VI. Total All Revenue</b> (III +V)	\$ 11,895,605	11,895,605			

\* 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)
<b>Total Other Resident Revenue - Medicare</b>		\$ -	\$ -	\$ -

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

Page Ref	Description	CCNH	RHNS	(Specify)
NA	Misc Revenues from CRF funds	\$ 474,763		
	Med B Supplies	\$ 5,283		
	Medicaid Retro	\$ (88,817)		
	Medicare Retro	\$ 3,230		
<b>Total Other Resident Revenue</b>		\$ 394,459	\$ -	\$ -

**Interest Income****Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
pg 31,L A2	Interest on AR	NA	\$ 1,638		
pg 31,L A1	Interest on reserve account	NA	\$ 472		
<b>Total Interest Income</b>		\$ 2,110	\$ -	\$ -	

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
	cell tower income	\$ 28,323		
	bad debt recoveries	\$ 13,130		
	Donations/class action settlements	\$ 1,773		
<b>Total Other Revenue</b>		\$ 43,226	\$ -	\$ -

**G. Balance Sheet**

Name of Facility New Horizons Inc. d/b/a Cherry Brook	License No. 2125C	Report for Year Ended 9/30/2022	Page 31	of 37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$ 771,770	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 1,466,540	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$ 17,998	
5. Prepaid Expenses			\$ 239,129	
a. Prepaid Insurance 165,399				
b. Prepaid Expenses ( <i>itemize</i> ) 73,730				
c. _____				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$ 22,183	
A/R facilities Non Related 7,000				
Medicaid Cost settlement 15,183				
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$ 2,517,620	
B. Fixed Assets				
1. Land			\$ 1,000,000	
2. Land Improvements *Historical Cost 321,606			\$ 74,504	
Accum. Depreciation 247,102 Net				
3. Buildings *Historical Cost 7,715,329			\$ 859,814	
Accum. Depreciation 6,855,515 Net				
4. Leasehold Improvements *Historical Cost			\$	
Accum. Depreciation Net				
5. Non-Movable Equipment *Historical Cost 245,740			\$ 41,148	
Accum. Depreciation 204,592 Net				
6. Movable Equipment *Historical Cost 1,036,028			\$ 161,308	
Accum. Depreciation 874,720 Net				
7. Motor Vehicles *Historical Cost 6,000			\$	
Accum. Depreciation 6,000 Net				
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$ 46,970	
See Schedule 46,970				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$ 2,183,744	

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

(Carry Total forward to next page )

**Schedule of Prepaid Expenses Page 31 Line A5**

Page Ref	Line Ref	Description	
<b>Total Prepaid Expenses</b>			\$ -

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

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

**Schedule of Other Assets Page 32 Line D7**

Page Ref	Line Ref	Description	
<b>Total Other Assets</b>			\$ -

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

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

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			\$

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

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

Name of Facility New Horizons Inc. d/b/a Cherry Brook	License No. 2125C	Report for Year Ended 9/30/2022	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	4,701,364
<b>C. Leasehold or like property recorded for Equity Purposes.</b>				
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			\$	
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$	
<b>D. Investment and Other Assets</b>				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense	*Historical Cost	Accum. Depreciation	Net	\$
4. Goodwill (Purchased Only)			\$	60,800
5. Investments Related to Resident Care ( <i>itemize</i> )			\$	
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	
Name and Address	Amount	Loan Date		
7. Other Assets ( <i>itemize</i> )			\$	44,779
deferred Finance Fees		48,399		
Project Development		(3,620)		
See Schedule				
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$	105,579
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$	4,806,943

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2022	33	37
		Account	Amount	
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable				\$ 887,258
2. Notes Payable ( <i>itemize</i> )				\$
See Schedule				
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$ 297,505
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$
6. Accrued Payroll Taxes Payable				\$ 87,151
7. Medicare Final Settlement Payable				\$ 50,000
8. Medicare Current Financing Payable				\$
9. Mortgage Payable ( <i>Current Portion</i> )				\$
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )				\$ 2,809
11. Accrued Income Taxes*				\$
12. Other Current Liabilities ( <i>itemize</i> )				\$ 316,843
Accrued Operating expenses		173,108		
Provider taxes due		143,735		
See Schedule				
<b>A-13. Total Current Liabilities</b> (Lines A1 thru 12)				\$ 1,641,566

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

(Carry Total forward to next page)

## G. Balance Sheet (cont'd)

Name of Facility New Horizons Inc. d/b/a Cherry Brook HCC	License No. 2125C	Report for Year Ended 9/30/2022	Page 34	of 37
Account				Amount
Total Brought Forward:				1,641,566
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> )				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$ 1,127,493
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$ (5,111,619)
Name and Address of Lender	Amount	Loan Date		
New Horizons Inc	(5,111,619)			
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ (3,984,126)
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ (2,342,560)

## G. Balance Sheet (cont'd)

### Reserves and Net Worth

Name of Facility New Horizons Inc. d/b/a Cherry Brook	License No. 2125C	Report for Year Ended 9/30/2022	Page 35	of 37
Account				Amount
<b>A. Reserves</b>				
1. Reserve for value of leased land				\$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized				\$
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )				\$
4. Reserve for leasehold real properties on which fair rental value is based				\$
5. Reserve for funds set aside as donor restricted				\$
6. Total Reserves				\$
<b>B. Net Worth</b>				
1. Owner's Capital				\$
2. Capital Stock				\$
3. Paid-in Surplus				\$
4. Treasury Stock				\$
5. Cumulated Earnings				\$ 7,062,314
6. Gain or Loss for Period	10/1/2021	thru	9/30/2022	\$ 87,189
7. Total Net Worth				\$ 7,149,503
<b>C. Total Reserves and Net Worth</b>				\$ 7,149,503
<b>D. Total Liabilities, Reserves, and Net Worth</b>				\$ 4,806,943

## H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
New Horizons Inc. d/b/a Cherry Brook H	2125C	9/30/2022	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2021				\$ 7,062,317		
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )				\$ 11,895,605		
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )				\$ 11,808,416		
D. Net Income or Deficit				\$ 87,189		
E. Balance				\$ 7,149,506		
F. Additions						
1. Additional Capital Contributed ( <i>itemize</i> ) rounding				(3)		
2. Other ( <i>itemize</i> )						
F-3. Total Additions				\$ (3)		
G. Deductions						
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )				\$		
Name and Address (No., City, State, Zip)		Title	Amount			
2. Other Withdrawings ( <i>Specify</i> )				\$		
Purpose		Amount				
3. Total Deductions				\$		
H. <b>Balance at End of Period</b>				\$ 7,149,503		

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

Name of Facility New Horizons Inc. d/b/a Cherry Brook	License No. 2125C	Report for Year Ended 9/30/2022	Page 37	of 37
--	----------------------	------------------------------------	------------	----------

*Check appropriate category*

<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)
---	---	------------------------------------

### 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
-------------------------------

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

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

Contact Email Address lrinaldi@athenahealthcare.com
--