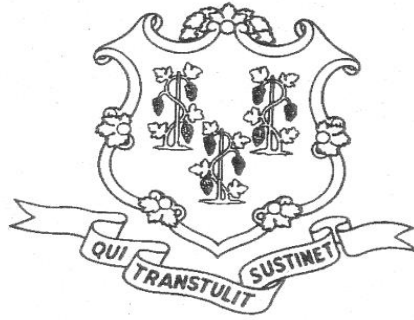


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2023

Name of Facility (as licensed) New Horizons Inc. d/b/a Cerry Brook HCC	
Address (No. & Street, City, State, Zip Code) 102 Dyer Avenue, Canton, CT 06019	
Type of Facility Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

License Numbers:	CCNH / RHNS 2125C	(Specify)	(Specify)	Medicare Provider 07-5396
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Medicaid Provider Numbers:	CCNH / RHNS 2125C	(Specify)	(Specify)
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General Information

Name of Facility (as licensed) New Horizons Inc. d/b/a Cerry Brook HCC	License No. 2125C	Report for Year Ended 9/30/2023	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for New Horizons Inc. d/b/a Cerry Brook HCC [facility name], for the cost report period beginning October 1, 2022 and ending September 30, 2023, 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)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility New Horizons Inc. d/b/a Cerry Brook HCC		Period Covered:	From 10/1/2022	To 9/30/2023
Address of Facility 102 Dyer Avenue, Canton, CT 06019				
Report Prepared By		Phone Number	Date	
Item	Total	CCNH / RHNS	(Specify)	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-693-7777		Report for Year Ended 9/30/2023	Page 2	of 37
Name of Facility (as shown on license) New Horizons Inc. d/b/a Cerry Brook HCC		Address (No. & Street, City, State, Zip) 102 Dyer Avenue, Canton, CT 06019		
License Numbers:	CCNH / RHNS 2125C	(Specify)	(Specify)	Medicare Provider No. 07-5396
Type of Facility (Check appropriate box(es)) Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box) <input type="checkbox"/> Proprietorship <input type="checkbox"/> LLC <input type="checkbox"/> Partnership <input type="checkbox"/> Profit Corp. <input checked="" type="radio"/> Non-Profit Corp. <input type="checkbox"/> Government <input type="checkbox"/> 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		License No.:		

General Information and Questionnaire Related Parties*

Name of Facility New Horizons Inc. d/b/a Cerry Brook HCC	License No. 2125C	Report for Year Ended 9/30/2023	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
New Horizons Inc	37 Bliss Memorial Rd, Collinsville CT 06085	<input type="radio"/>	<input checked="" type="radio"/>		Pension, Maintenance, legal, accounting	P 15, L1a7, P22, L6a	674,877	474,877
New Horizons Inc	37 Bliss Memorial Rd, Collinsville CT 06085	<input type="radio"/>	<input checked="" type="radio"/>		Cherry Brook participates in a common 401k	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"/>					
		<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 Cerry Brook HCC	License No. 2125C	Report for Year Ended 9/30/2023	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

Outpatient Services

General Information and Questionnaire
Other Lines of Business

Name of Facility New Horizons Inc. d/b/a Cerry Brook	License No. 2125C	Report for Year Ended 9/30/2023	Page 6	of 37
Square footage of entire facility. 0				
Outpatient Therapy				
Does the Facility provide outpatient therapy services?		No		
<i>If yes, please complete the following:</i>				
	Square footage of therapy space.			
Meals on Wheels				
Does the facility provide Meals on Wheels?		No		
<i>If yes, please complete the following:</i>				
	Square footage of kitchen			
	Number of meals served per week			
No	Are meals included in meals served on page 18 of the Annual Report?			
No	Are direct costs included in the Annual Report?			
<i>If yes, please state where costs are reported.</i>				
No	Are drivers for the program included in the facility's payroll?			
<i>If yes, please complete the following:</i>				
		Amount Reported		
		Annual Report page and line		
Please state the salary amounts of specific cooks and/or dietary aides				
Please state where the cooks and/or dietary aides are reported in the Annual Report				
Apartments, Independent Living, Assisted Living				
Does the facility have apartments, independent living, and/or assisted living?		No		
<i>If yes, please complete the following:</i>				
	Square footage of apartments			
	Square footage of independent living			
	Square footage of assisted living			
Please identify the services provided:				

General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility New Horizons Inc. d/t	License No. 2125C	Report for Year Ended 9/30/2023	Page 7	of 37
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Child Day Care

Does the Facility provide Child Day Care? No

If yes, please complete the following:

	Square footage of child day care space.
	Average number of daily participants.
	Number of meals per day provided to child day care.
	Nature of services provided:

Adult Day Care

Does the Facility provide Adult Day Care? No

If yes, please complete the following:

	Square footage of adult day care space.
	Please state where it is located in relation to the facility.
	Average number of daily participants.
	Number of meals per day provided to adult day care.
	Nature of services provided:

Schedule of Resident Statistics

Name of Facility New Horizons Inc. d/b/a Cerry Brook HCC			License No. 2125C		Report for Year Ended 9/30/2023				Page 8		of 37	
	Total All Levels	Total CCNH / RHNS Level	Total	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH / RHNS	(Specify)	(Specify)	Total	CCNH / RHNS	(Specify)	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	100	100			100	100						
B. On last day of THIS report period	100	100							100	100		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	85	85			85	85						
B. As of midnight of THIS report period	86	86							86	86		
3. Total Number of Days Care Provided During Period												
A. Medicare	3,795	3,795			2,841	2,841			954	954		
B. Medicaid (Conn.)	23,092	23,092			16,908	16,908			6,184	6,184		
C. Medicaid (other states)												
D. Private Pay	3,623	3,623			2,857	2,857			766	766		
E. State SSI for RCH												
F. Other (Specify)	100	100			77	77			23	23		
G. Total Care Days During Period (3A thru F)	30,610	30,610			22,683	22,683			7,927	7,927		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	30,610	30,610			22,683	22,683			7,927	7,927		

Schedule of Resident Statistics (Cont'd)

Name of Facility New Horizons Inc. d/b/a Cerry Brook HCC	License No. 2125C	Report for Year Ended 9/30/2023	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year? Yes No
 If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change	
	CCNH / RHNS	(Specify)	(Specify)	Lost			Gained			CCNH / RHNS	(Specify)	(Specify)		
	(1)	(2)	(3)	(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)	(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 / RHNS	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	(Specify)	R.C.H.	ICF-MR
No. of Residents	4	68		8		6		
Per Diem Rate								
a. One bed rm.	514.35	#####		651.00		368.00		
b. Two bed rms.	514.35	#####		639.00		368.00		
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B	3,954	3,954			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	74	74			
2. Restorative Treatments					
C. Other	8,385	8,385			
D. Total Physical Therapy Treatments	12,413	12,413			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	754	754			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	18	18			
2. Restorative Treatments					
C. Other	840	840			
D. Total Speech Therapy Treatments	1,612	1,612			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	4,761	4,761			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	8	8			
2. Restorative Treatments					
C. Other	8,313	8,313			
D. Total Occupational Therapy Treatments	13,082	13,082			

Annual Report of Long-Term Care Facility

CSP-10 Rev. 3/2023

Report of Expenditures - Salaries & Wages

Name of Facility New Horizons Inc. d/b/a Cerry Brook HCC	License No. 2125C	Report for Year Ended 9/30/2023	Page 10	of 37
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Are time records maintained by all individuals receiving compensation? Yes No

Item	Total Cost and Hours									
	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	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)	160,759		2,089							
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)										
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	250,881		10,136							
5. Dietary Service										
a. Head Dietitian										
b. Food Service Supervisor	73,051		2,081							
c. Dietary Workers	472,566		23,745							
6. Housekeeping Service										
a. Head Housekeeper	65,376		2,365							
b. Other Housekeeping Workers	246,388		13,813							
7. Repairs & Maintenance Services										
a. Engineer or Chief of Maintenance	67,772		2,139							
b. Other Maintenance Workers	45,523		2,163							
8. Laundry Service										
a. Supervisor										
b. Other Laundry Workers	97,773		5,524							
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	223,939		4,248							
b. RN										
1. Direct Care	631,743		12,420							
2. Administrative**	551,960		15,411							
c. LPN										
1. Direct Care	1,107,342		28,986							
2. Administrative**										
d. Aides and Attendants	1,322,152		51,257							
e. Physical Therapists	548,146		13,812							
f. Speech Therapists	68,394		1,480							
g. Occupational Therapists	269,802	(269,805)	6,534							
h. Recreation Workers	124,997		5,892							
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	161,358	(4,805)	4,908							
n. Marketing										
o. Other (Specify) See Attached Schedule										
<i>A-13. Total Salary Expenditures</i>	6,489,922	(274,610)	209,003							

* 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 in the Adjustment column.

**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	
New Horizons Inc. d/b/a Cerry Brook HCC				2125C	9/30/2023			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)	(Specify)							
Section I - Operators/Owners										
N/A										
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).										
N/A										

* 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.

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
New Horizons Inc. d/b/a Cerry Brook HCC				2125C	9/30/2023			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)	(Specify)							
Section III - Administrators***										
John Zazzaro	160,759			Health & Life insurane, payroll Taxes	Day to day operations of the nursing home facility.	2,089	A2			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended						Page	of
New Horizons Inc. d/b/a Cerry Brook HCC	2125C	9/30/2023						13	37
Total Cost and Hours									
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	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	14,490		410						
2. Dentist	9,092		37						
3. Pharmacist	10,335		112						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care									
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	45,100		153						
b. Utilization Review (Title 18 and 19 only) monthly meeting									
c. Resident Care**	1,951	(1,951)							
d. Administrative Services facility									
1. Infection Control Committee (Quarterly meetings)									
2. Pharmaceutical Committee (Quarterly meetings)									
3. Staff Development Committee (Once annually)									
e. Other (Specify) See Attached Schedule	1,700		17						
9. Speech Therapist									
a. Resident Care	2,160		6						
b. Other									
10. Occupational Therapist									
a. Resident Care									
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	43,360		637						
2. Administrative***									
b. LPN									
1. Direct Care	259,080		3,857						
2. Administrative***									
c. Aides	928,075		24,065						
d. Other									
12. Other (Specify) See Attached Schedule									
B-13 Total Fees Paid in Lieu of Salaries	1,315,343	(1,951)	29,294						

* 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 in the Adjustment column.

*** 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 Cerry Brook HCC		License No. 2125C		Report for Year Ended 9/30/2023		Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship			
		Yes	No				
Michaela Lux, 9 Feetwood Drive, Plainville, CT 06062	Dietician	<input type="radio"/>	<input checked="" type="radio"/>				
The Nurse Network, 653 Main St, Plainville, CT 06479	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>				
Garry Miller MD, 61 Bradley St, Bristol, CT 06010	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>				
Norton & Associates, 34 Elm St, 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"/>				
Sheldon Kafer, M.D. 75 Vincent Ave, Stamford, CT 06905	Physician	<input type="radio"/>	<input checked="" type="radio"/>				
SDX Dysphagia Experts, 21 Waterville Rd., Avon, CT 06001	Speech Ttherapy Services	<input type="radio"/>	<input checked="" type="radio"/>				
Health Drive Dental, PO Box 22010, New York, NY 10087-2010	Dental Consulting	<input type="radio"/>	<input checked="" type="radio"/>				
Intelcare Inc, PO Box 787317, Philadelphia, PA	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>				
VauleRX Pharmacy Services, 54 Tuttle Place, Middlwtown, CT 06457	Pharmacy Connsultant	<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"/>				
Health Drive EyeCare Group, 100 Crossing BLVD, T 300, Framingham, MA	Physician services	<input type="radio"/>	<input checked="" type="radio"/>				
Dr Isaac Bosco DMD., 191 Albany Turnpike, Canton, CT	Dental Consulting	<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"/>				
Health Drive Audiology, 100 Crossing BLVD, ST 300, Framingham, MA	Physician services	<input type="radio"/>	<input checked="" type="radio"/>				
Bristol Hospital, 41 Brewster Rd. Bristol, CT	Physician services	<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.
 ** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended					Page	of
New Horizons Inc. d/b/a Cerry Brook HCC	2125C	9/30/2023					15	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
I. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	\$ 218,252	218,252						
2. Disability Insurance	\$							
3. Unemployment Insurance	\$ 32,167	32,167						
4. Social Security (F.I.C.A.)	\$ 472,186	472,186						
5. Health Insurance	\$ 617,557	617,557						
6. Life Insurance (employees only) (not-owners and not-operators)	\$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 228,628	228,628						
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*	\$	88,574	(88,574)					
d. Accounting and Auditing	\$ 40,950	40,950						
e. Legal (<i>Services should be fully described on Page 15b</i>)	\$	3,927	(3,927)					
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$							
g. Office Supplies	\$ 65,953	65,953						
h. Telephone and Cellular Phones								
1. Telephone & Pagers	\$ 26,087	26,087						
2. Cellular Phones	\$ 1,378	2,580	(1,202)					
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	\$ 564,114	564,114						
Subtotal	\$ 2,267,272	2,360,975	(93,703)					

* Facility should self-disallow the expense in the Adjustment column.

(Carry Subtotals forward to next page)

General Information and Questionnaire Accounting Basis

Name of Facility New Horizons Inc. d/b/a Cerry Bro	License No. 2125C	Report for Year Ended 9/30/2023	Page 15b	of 37
The records of this facility for the period covered by this report were maintained on the following basis:				
<input checked="" type="radio"/> Accrual <input type="radio"/> Cash <input type="radio"/> Modified Cash				
Is the accounting basis for this period the same as for the previous period? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain.				
Independent Accounting Firm				
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)		
1 CohnReznick LLP		350 Church St, hartford, CT 06103		
2 Marcum LLP		555 Long Wharf Drive, New Haven, CT 06511		
3				
4				
Services Provided by This Firm (<i>describe fully</i>)				
1 Audit & Year End Financials				\$ 38,115
2 Medicare Cost Report				\$ 2,835
3				\$
4				\$
				Charge for Services Provided
				\$ 40,950
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="radio"/> Yes <input type="radio"/> No				
Legal Services Information				
Name of Legal Firm or Independent Attorney			Telephone Number	
1 Pilicy & Ryan, PC			860-274-0018	
2 Goldman, Gruder & Woods				
3 Wiggin & Dana				
4				
5				
Address (<i>No. & Street, City, State, Zip Code</i>)				
1				
2				
3				
4				
5				
Services Provided by This Firm (<i>describe fully</i>)				
1 Collections:Disallowed				\$ 200
2 Collections:Disallowed				\$ 300
3 Legal Council: Disallowed				\$ 3,427
4				\$
5				\$
				Charge for Services Provided
				\$ 3,927
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="radio"/> Yes <input type="radio"/> No				

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

Name of Facility	License No.	Report for Year Ended					Page	of
New Horizons Inc. d/b/a Cerry Brook HCC	2125C	9/30/2023					16	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
Subtotals Brought Forward:	2,267,272	2,360,975	(93,703)					
1. Travel and Entertainment								
1. Resident Travel and Entertainment \$								
2. Holiday Parties for Staff \$								
3. Gifts to Staff and Residents \$		6,825	(6,825)					
4. Employee Travel \$	74	74						
5. Education Expenses Related to Seminars and Conventions \$	5,155	5,155						
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>) \$	22,916	22,916						
2. Advertising Telephone Directory (<i>all such expenses</i>)*** \$								
3. Advertising Other (<i>Specify</i>)*** \$		8,064	(8,064)					
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 \$	3,258	3,258						
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) \$	10,876	10,876						
See Attached Schedule								
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.*** \$								
9. Subscriptions \$	454	454						
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>) \$	63,495	275,378	(211,883)					
See Attached Schedule								
C-14 Total Administrative & General Expenditures	\$ 2,545,100	2,865,575	(320,475)					

* 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 in the Adjustment column.

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Promotional	\$ 8,064	\$ (8,064)				
Total Other Advertising	\$ 8,064	\$ (8,064)	\$ -	\$ -	\$ -	\$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Leading Age of CT	\$ 10,526					
CAHCF	\$ 350					
Total Dues	\$ 10,876	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Total Contributions	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
ST of CT- Annual License renewal	\$ 274					
Bank charges	\$ 11,883	\$ (11,883)				
Payroll processing fees	\$ 12,585					
Employee Physicals/ background checks	\$ 3,751					
management fee-New Horizons	\$ 200,000	\$ (200,000)				
Cell phone tower consulting	\$ 2,560					
data processing fees	\$ 44,325					
Total Other Administrative and General	\$ 275,378	\$ (211,883)	\$ -	\$ -	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
New Horizons Inc. d/b/a Cerry Brook HC	2125C	9/30/2023	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.	223,200	Contract attached to a prior year	See below
Allocation of the above	147,312	Admin/Gen 66%	PG 16, Line 12
	35,712	Indirect 16%	Pg 20, Line 5k
	40,176	Direct 18%	Pg 20, Line 5J
Athena Health Care Assoc., Inc.	24,288	Admin/Gen - Other Exp	Pg 16, Line 12
New Horizons Inc	200,000	Admin 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
New Horizons Inc. d/b/a Cerry Brook HCC		2125C	9/30/2023				18	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	\$ 314,146	314,146						
2. Non-Food Supplies	\$ 42,298	42,298						
3. Other (Specify) _____ Dishes & Utencils	\$ 267	267						
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$							
c. Other (Specify) _____ Management Services	\$ 35,712	35,712						
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 392,423	392,423						
2E. Dietary Questionnaire		Total	CCNH / RHNS		(Specify)	(Specify)		
F. Resident Meals: Total no. of meals served per day:*	252	252						
G. Is cost of employee meals included in 2D?	<input checked="" type="radio"/> Yes	<input type="radio"/> No						
H. Did you receive revenue from employees?	<input checked="" type="radio"/> Yes	<input type="radio"/> No			If yes, specify amt.			
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		License No.	Report for Year Ended				Page	of
New Horizons Inc. d/b/a Cerry Brook HCC		2125C	9/30/2023				19	37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
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. \$	14,593	14,593					
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$							
c. Other (Specify) Supplies	\$	8,136	8,136					
3D. Total Laundry Expenditures (3a + b + c)	\$	22,729	22,729					
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
New Horizons Inc. d/b/a Cerry Brook HCC		2125C	9/30/2023				20	37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4.	Housekeeping							
	a. In-House Care	Sq. Ft. Serviced by Personnel						
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	45,910	45,910				
	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. \$	30,688	30,688				
	c. Other (<i>Specify</i>)	\$						
4D.	Total Housekeeping Expenditures (4a + b + c)	\$	76,598	76,598				
5.	Resident Care (Supplies)**							
	a. Prescription Drugs***							
	1. Own Pharmacy	\$						
	2. Purchased from Value RX	\$	186,079	(186,079)				
	b. Medicine Cabinet Drugs	\$	124	17,899	(17,775)			
	c. Medical and Therapeutic Supplies	\$	253,724	253,724				
	d. Ambulance/Limousine***	\$	5,051	(5,051)				
	e. Oxygen							
	1. For Emergency Use	\$						
	2. Other***	\$	13,159	(13,159)				
	f. X-rays and Related Radiological Procedures***	\$	18,009	(18,009)				
	g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$						
	h. Laboratory***	\$	40,136	(40,136)				
	i. Recreation	\$	15,664	15,664				
	j. Direct Management Services*	\$	40,176	40,176				
	k. Indirect Management Services*	\$						
	l. Cable TV	\$	4,412	22,630	(18,218)			
	m. Other (Specify)**** See Attached Schedule	\$	57,866	65,327	(7,461)			
	n. Physical Therapy Expense	\$						
	o. Speech Therapy Expense	\$						
5P.	Total Resident Care Expenditures (5a - 5o)	\$	371,966	677,854	(305,888)			

* 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 in the Adjustment column.
 **** ICFMR's should provide a detailed schedule of all Day Program Costs.

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

Name of Facility New Horizons Inc. d/b/a Cerry Brook HCC			License No. 2125C		Report for Year Ended 9/30/2023				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.***				
		Yes	No			CCNH / RHNS	(Specify)	(Specify)	Pg	Line
Better Blades	PO Box 131, New Hartford, CT	<input type="radio"/>	<input checked="" type="radio"/>	Groundskeeping, Snow Removal		53,350			22	6f
CWPM	25 Norton Place, PO Box 415, Plainville, CT	<input type="radio"/>	<input checked="" type="radio"/>	Rubbish Removal		25,344			22	6f
Athena Health care Associates	135 South Rd., Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>	Managament Services		247,488			17	
ADP	100 Corporate Drive, Windsor, CT	<input type="radio"/>	<input checked="" type="radio"/>	Payroll Processing		12,585			16	m13
ValueRX Pharmacy Services	54 Tuttle Place, Middlwtown, CT 06457	<input type="radio"/>	<input checked="" type="radio"/>	Pharmacy Services		214,182			20	5a2
Primary Cleaning Inc	68 Bridge St, ST 310, Sufflied, CT 06078	<input type="radio"/>	<input checked="" type="radio"/>	P/S housekeeping		30,688			20	4b
		<input type="radio"/>	<input checked="" type="radio"/>						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	License No.	Report for Year Ended					Page	of
New Horizons Inc. d/b/a Cerry Brook HCC	2125C	9/30/2023					22	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	\$ 90,445	90,445						
b. Heat	\$ 46,571	46,571						
c. Light & Power	\$ 160,918	160,918						
d. Water	\$ 48,607	48,607						
e. Equipment Lease (<i>Provide detail on page 22b</i>)	\$ 12,882	12,882						
f. Other (<i>itemize</i>)	\$ (243)		(243)					
See Attached Schedule								
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 359,180	359,423	(243)					
7. Depreciation (<i>complete schedule page 23*</i>)								
a. Land Improvements	\$ 27,533	27,533						
b. Building & Building Improvements	\$ 292,132	292,132						
c. Non-Movable Equipment	\$ 5,474	5,474						
d. Movable Equipment	\$ 37,931	49,372	(11,441)					
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 363,070	374,511	(11,441)					
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. Total Amortization Costs (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	\$ 22,877	22,877						
b. Real estate taxes paid by lessor	\$							
c. Personal property taxes	\$ 12,883	12,883						
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 416,980	428,421	(11,441)					

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

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
New Horizons Inc. d/b/a Cerry Brook HCC			2125C	9/30/2023			22b	37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
LEAF	<input type="radio"/>	<input checked="" type="radio"/>	Copiers	12/19/19	48 months	11,748	11,747	
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	<input type="radio"/>	<input checked="" type="radio"/>	Postal Equipment	04/01/18	60 months	1,135	1,135	
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
							Total ***	12,882

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.

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
4/1/2023	Fire Doors	\$ 9,425	20	\$ 236
9/1/2023	Slider Window	\$ 3,380	20	\$ 85
Total additions for Building Improvements		\$ 12,805		\$ 321 *
Deletions:				
Total deletions for Building Improvements		\$ -		\$ - **

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
Additions:					
11/1/2022	WheelChair	Standard Resident	\$ 1,411	10	\$ 71
4/1/2023	portable air purifier	Standard Resident	\$ 3,380	5	\$ 338
5/1/2023	resident furniture	Standard Resident	\$ 7,596	12	\$ 317
6/1/2023	steamer	Standard Resident	\$ 6,149	10	\$ 307
4/1/2026	computer equipment	Administrative	\$ 1,182	3	\$ 197
6/1/2023	computer equipment	Administrative	\$ 2,116	33	\$ 353
8/1/2023	ice maker	Standard Resident	\$ 6,849	10	\$ 342
7/1/2023	outdorr chairs	Standard Resident	\$ 1,183	5	\$ 118
8/1/2023	scale actuator/boom assembly	Standard Resident	\$ 2,720	10	\$ 136
5/1/2023	RMA parts	Standard Resident	\$ 3,432	5	\$ 343
5/1/2023	furniture/wall art	Administrative	\$ 1,515	15	\$ 51
Total additions for Movable Equipment			\$ 37,533		\$ 2,573 *
Deletions:					
Total deletions for Movable Equipment			\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

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

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility			License No.		Report for Year Ended			Page	of
New Horizons Inc. d/b/a Cerry Brook HCC			2125C		9/30/2023			24	37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1. Finance Fees-CHEFA	9	1994	30 Years	922,570	922,570	S/L			
2. Finance Fees-Farmington Bank	12	2014	10 Years	194,356	127,951	S/L			
3. Finance Fees-ION Bank	6	2021	4 Years	72,599		S/L		18,150	
B-4. Subtotal									18,150
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									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 Cerry Brook	License No. 2125C	Report for Year Ended 9/30/2023	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> 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					
6. Square Footage					
7. Acquisition Cost					
a. Land	1,000,000				
b. Building	6,039,220				
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)	Fixed				
b. Date Mortgage Obtained	12/10/14				
c. Interest Rate for the Cost Year	299.00%				
d. Term of Mortgage (number of years)	4				
e. Amount of Principal Borrowed	1,625,000				
f. Principal balance outstanding as of _____	686,721				
Complete if Mortgage was Refinanced During Current Cost Year					
g. Type of Financing (e.g., fixed, variable)	Fixed				
h. Date of Refinancing	06/02/21				
i. New Interest Rate	299.00%				
j. Term of Mortgage (number of years)	4				
k. Amount of Principal Borrowed	1,625,000				
l. Principal Outstanding on Note Paid-Off	1,653,088				
Part C - Arms-Length Leases for Real Property Improvements Only					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	

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

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

Name of Facility		License No.	Report for Year Ended				Page	of
New Horizons Inc. d/b/a Cerry Brook		2125C	9/30/2023				26	37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
12. Interest								
A. Building, Land Improvement & Non-Movable Equipment								
1. First Mortgage		\$ 28096	28,096					
Name of Lender		Rate						
Farmington Bank								
Address of Lender								
One Farm Glan BLVD Farmington, CT 06032								
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)		\$ 28,096	28,096					

(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				Page	of	
New Horizons Inc. d/b/a Cerry Bro		2125C		9/30/2023				27	37	
Item				Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:				28,096	28,096					
12. C. Movable Equipment										
1. Automotive Equipment										
A. Item				Rate	Amount					
Lender										
Address of Lender										
2. Other (Specify)										
A. Item				Rate	Amount					
Lender										
Address of Lender										
B. Item				Rate	Amount					
Lender										
Address of Lender										
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)										
12. D. Other Interest Expense (Specify)										
Vendor Interest					476	(476)				
13. Total All Interest Expense (12B7 + 12C3 + 12D)										
				\$ 28,096	28,572	(476)				
14. Insurance										
a. Insurance on Property (buildings only)										
				\$ 176,067	176,067					
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)										
				\$ 176,067	176,067					
15. Total All Expenditures (A-13 thru C-14)										
				\$ 11,917,843	12,832,927	(915,084)				

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
New Horizons Inc. d/b/a Cerry Brook HC 2125C		9/30/2023		30	37
Item	Total	CCNH / RHNS	(Specify)	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 14,048,075	14,048,075			
b. Medicaid Room and Board Contractual Allowance **	\$ (7,120,842)	(7,120,842)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,131,280	1,131,280			
b. Medicare Room and Board Contractual Allowance **	\$ 121,076	121,076			
4. a. Private-Pay Residents and Other	\$ 3,333,259	3,333,259			
b. Private-Pay Room and Board Contractual Allowance **	\$ (310,734)	(310,734)			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 28,239	28,239			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (25,914)	(25,914)			
c. Prescription Drugs - Non-Medicare	\$ 44,099	44,099			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (44,099)	(44,099)			
2. a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$ 1,790	1,790			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (1,790)	(1,790)			
3. a. Physical Therapy - Medicare	\$ 650,720	650,720			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (435,647)	(435,647)			
c. Physical Therapy - Non-Medicare	\$ 233,150	233,150			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (233,150)	(233,150)			
4. a. Speech Therapy - Medicare	\$ 139,905	139,905			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (96,217)	(96,217)			
c. Speech Therapy - Non-Medicare	\$ 50,559	50,559			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (50,559)	(50,559)			
5. a. Occupational Therapy - Medicare	\$ 480,624	480,624			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (344,041)	(344,041)			
c. Occupational Therapy - Non-Medicare	\$ 235,805	235,805			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (235,805)	(235,805)			
6. a. Other (<i>Specify</i>) - Medicare	\$				
b. Other (<i>Specify</i>) - Non-Medicare	\$ 12,012	12,012			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 11,611,795	11,611,795			
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$ 14,058	14,058			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ 19,601	48,754	(29,153)		
V. Total Other Revenue (1 thru 8)	\$ 33,659	62,812	(29,153)		
VI. Total All Revenue (III +V)	\$ 11,645,454	11,674,607	(29,153)		

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
	Med B Medical Supplies	\$ 4,768		
	Medicare Retro	\$ 7,244		
Total Other Resident Revenue		\$ 12,012	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	(Specify)
Pg 31, 1 A2	Interest on A/R	N/A	\$ 230		
Pg 31, L A1	Interest on Reserve Account	N/A	\$ 13,828		
Total Interest Income			\$ 14,058	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
	Cell Tower Income	\$ 29,153	\$ (29,153)	
	Bad Debt Recoveries	\$ 5,293		
	Donations	\$ 14,308		
Total Other Revenue		\$ 48,754	\$ (29,153)	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
New Horizons Inc. d/b/a Cerry Brook H	2125C	9/30/2023	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	674,072
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,457,961
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	19,839
5. Prepaid Expenses			\$	213,619
a. Prepaid Insurance	46,889			
b. Prepaid Expenses	166,730			
c. _____				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	7,000
A/R Facilities : Non Related	7,000			

See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	2,372,491
B. Fixed Assets				
1. Land			\$	1,000,000
2. Land Improvements	*Historical Cost	321,606	\$	46,971
	Accum. Depreciation	274,635	Net	
3. Buildings	*Historical Cost	7,728,134	\$	580,487
	Accum. Depreciation	7,147,647	Net	
4. Leasehold Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____	Net	
5. Non-Movable Equipment	*Historical Cost	245,740	\$	35,674
	Accum. Depreciation	210,066	Net	
6. Movable Equipment	*Historical Cost	1,085,000	\$	160,908
	Accum. Depreciation	924,092	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>)			\$	35,529
Excluded Moveable Equipment	49,048			
See Schedule	(13,519)			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	1,859,569

* 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	
		Misc Diff fixed assets to books	\$ (13,519)
Total Other Other Fixed Assets (Itemize)			\$ (13,519)

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)			\$ -

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
New Horizons Inc. d/b/a Cerry Brook H	2125C	9/30/2023	32	37
Account			Amount	
Total Brought Forward:			\$	4,232,060
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Non-Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
5. Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
6. Motor Vehicles				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	60,800
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	30,250
Name and Address	Amount	Loan Date		
	30,250			
7. Other Assets (<i>itemize</i>)			\$	(5,900)

(5,900)				

See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	85,150
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	4,317,210

* 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 New Horizons Inc. d/b/a Cerry Brook HCC		License No. 2125C	Report for Year Ended 9/30/2023	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	1,871,585
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>)				\$	300,813
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	144,182
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>)				\$	245,038
Acc'd Operating Expenses		98,466			
Provider Taxes Due		146,572			

See Schedule					
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	2,614,427

* 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 Cerry Brook HCC	License No. 2125C	Report for Year Ended 9/30/2023		Page 34	of 37
Account				Amount	
Total Brought Forward:				2,614,427	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					
				\$	
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable				\$ 686,721	
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$ (4,861,619)	
Name and Address of Lender	Amount	Loan Date			
	(4,861,619)				
4. Other Long-Term Liabilities (<i>itemize</i>)				\$	
See Schedule					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ (4,174,898)	
C. Total All Liabilities (Lines A-13 + B-5)				\$ (1,560,471)	

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

Name of Facility	License No.	Report for Year Ended	Page	of
New Horizons Inc. d/b/a Cerry Brook	2125C	9/30/2023	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	7,149,498
6. Gain or Loss for Period			\$	(1,271,817)
7. Total Net Worth			\$	5,877,681
C. Total Reserves and Net Worth			\$	5,877,681
D. Total Liabilities, Reserves, and Net Worth			\$	4,317,210

H. Changes in Total Net Worth

Name of Facility New Horizons Inc. d/b/a Cerry Brook HC	License No. 2125C	Report for Year Ended 9/30/2023	Page 36	of 37	
Account			Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2022			\$	7,149,503	
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	11,674,607	
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	12,946,424	
D. Net Income or Deficit			\$	(1,271,817)	
E. Balance			\$	5,877,686	
F. Additions					
1. Additional Capital Contributed (<i>itemize</i>)					
Rounding	(5)				
2. Other (<i>itemize</i>)					
F-3. Total Additions			\$	(5)	
G. Deductions					
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$		
Name and Address (<i>No., City, State, Zip</i>)	Title	Amount			
2. Other Withdrawings (<i>Specify</i>)			\$		
Purpose	Amount				
3. Total Deductions			\$		
H. Balance at End of Period			\$	5,877,681	

I. Preparer's/Reviewer's Certification

Name of Facility New Horizons Inc. d/b/a Cerry Brook	License No. 2125C	Report for Year Ended 9/30/2023	Page 37	of 37
<i>Check appropriate category</i>				
Chronic and Convalescent Nursing <input checked="" type="checkbox"/> Home (CCNH) & RHNS Combined	<input type="checkbox"/> (Specify)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>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.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Athena Health Care Associates				
Address Address			Phone Number	
135 South Rd, Farmington, CT 06032			860-751-3900	
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number	
Amanda Doncet			860-751-3900	
Contact Email Address				
adoncet@athenahealthcare.com				