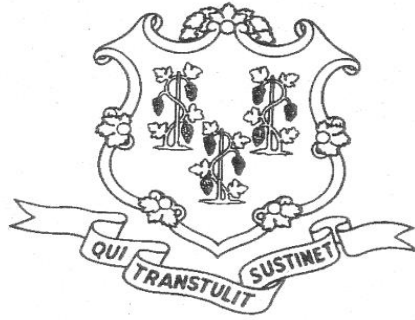


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2023

Name of Facility (as licensed) Colonial Health and Rehab Center of Plainfield, LLC	
Address (No. & Street, City, State, Zip Code) 16 Windsor Ave, Plainfield, CT 06374	
Type of Facility Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <span style="margin-left: 150px;"><input type="checkbox"/> (Specify)</span> <span style="margin-left: 150px;"><input type="checkbox"/> (Specify)</span>	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

License Numbers:	CCNH / RHNS 2387	(Specify)	(Specify)	Medicare Provider 07-5310
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Medicaid Provider Numbers:	CCNH / RHNS 2387	(Specify)	(Specify)
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**General Information**

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Colonial Health and Rehab Center of Plainfield, LLC	2387	9/30/2023	1	37

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

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR 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 Colonial Health and Rehab Center of Plainfield, LLC [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) Curtis Rodowicz			Printed Name (Owner) Colonial Health & Rehab LLC		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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 Colonial Health and Rehab Center of Plainfield, LLC		Period Covered:	From 10/1/2022	To 9/30/2023
Address of Facility 16 Windsor Ave, Plainfield, CT 06374				
Report Prepared By CJLC LLC		Phone Number 860-610-9009	Date 1/31/2024	
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. <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 860-564-4081		Report for Year Ended 9/30/2023	Page 2	of 37
Name of Facility (as shown on license) Colonial Health and Rehab Center of Plainfield, LLC		Address (No. & Street, City, State, Zip) 16 Windsor Ave, Plainfield, CT 06374		
License Numbers:	CCNH / RHNS 2387	(Specify)	(Specify)	Medicare Provider No. 07-5310
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="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input 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.				
<b>Administrator</b>				
Name of Administrator Curtis Rodowicz		Nursing Home Administrator's License No.:	1775	
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 Colonial Health and Rehab Center of Plainfield, LLC	License No. 2387	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	%**				
Colonial Health & Rehab Management LLC	2385 NW Executive Center Dr., Boca Raton, FL 33431	<input type="radio"/>	<input checked="" type="radio"/>		Management Services	16/m12	306,953	178,241
Family First of Plainfield	2385 NW Executive Center Dr., Boca Raton, FL 33431	<input type="radio"/>	<input checked="" type="radio"/>		Rent of Facility	22/9	665,750	Fully Disallowed
Covered Staffing LLC	2385 NW Executive Center Dr., Suite 100, Boca Raton, FL 33431	<input checked="" type="radio"/>	<input type="radio"/>		Nursing Pool	13/11c	308,874	291,819
The Law Firm of Joseph Rodowicz		<input type="radio"/>	<input checked="" type="radio"/>		Law Services	15/1e	1,459	1,459
		<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	License No.	Report for Year Ended	Page	of
Colonial Health and Rehab Center of Plainfield	2387	9/30/2023	5	37

If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist ( <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.

**General Information and Questionnaire**  
**Other Lines of Business**

Name of Facility Colonial Health and Rehab Center of	License No. 2387	Report for Year Ended 9/30/2023	Page 6	of 37
Square footage of entire facility. <span style="float:right; border: 1px solid black; padding: 2px;">0</span>				
<b>Outpatient Therapy</b>				
Does the Facility provide outpatient therapy services?		No		
<i>If yes, please complete the following:</i>				
	Square footage of therapy space.			
<b>Meals on Wheels</b>				
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				
<b>Apartments, Independent Living, Assisted Living</b>				
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 Colonial Health and R	License No. 2387	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			License No.		Report for Year Ended				Page		of	
Colonial Health and Rehab Center of Plainfield, LLC			2387		9/30/2023				8		37	
	Total All Levels	Total CCNH / RHNS Level	Total (Specify)	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	90	90			90	90						
B. On last day of THIS report period	90	90							90	90		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	82	82			82	82						
B. As of midnight of THIS report period	85	85							85	85		
3. Total Number of Days Care Provided During Period												
A. Medicare	3,614	3,614			2,799	2,799			815	815		
B. Medicaid (Conn.)	21,731	21,731			16,229	16,229			5,502	5,502		
C. Medicaid (other states)												
D. Private Pay	3,080	3,080			2,072	2,072			1,008	1,008		
E. State SSI for RCH												
F. Other (Specify) Commercial, Managed Care	1,988	1,988			1,557	1,557			431	431		
G. Total Care Days During Period (3A thru F)	30,413	30,413			22,657	22,657			7,756	7,756		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	76	76			18	18			58	58		
B. Other Bed Reserve Days												
5. <b>Total Resident Days (3G + 4A + 4B)</b>	30,489	30,489			22,675	22,675			7,814	7,814		

### Schedule of Resident Statistics (Cont'd)

Name of Facility Colonial Health and Rehab Center of Plainfield, LL	License No. 2387	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)	CCNH / RHNS	(Specify)	(Specify)	

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

Change in Resident Days	CCNH / RHNS	(Specify)	(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	15	63		7				
Per Diem Rate								
a. One bed rm.	661.00	#####		405.00				
b. Two bed rms.				385.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B	3,031	3,031			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments	4	4			
C. Other	10,971	10,971			
<b>D. Total Physical Therapy Treatments</b>	<b>14,006</b>	<b>14,006</b>			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	459	459			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other	1,467	1,467			
<b>D. Total Speech Therapy Treatments</b>	<b>1,926</b>	<b>1,926</b>			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	2,843	2,843			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments	2	2			
C. Other	10,795	10,795			
<b>D. Total Occupational Therapy Treatments</b>	<b>13,640</b>	<b>13,640</b>			

Annual Report of Long-Term Care Facility

CSP-10 Rev. 3/2023

Report of Expenditures - Salaries & Wages

Name of Facility Colonial Health and Rehab Center of Plainfield, LLC	License No. 2387	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)	116,206		2,200							
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)										
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	231,644		5,989							
5. Dietary Service										
a. Head Dietitian										
b. Food Service Supervisor	62,984		2,214							
c. Dietary Workers	375,192		18,430							
6. Housekeeping Service										
a. Head Housekeeper	41,011		2,192							
b. Other Housekeeping Workers	213,376		11,765							
7. Repairs & Maintenance Services										
a. Engineer or Chief of Maintenance	47,870		1,655							
b. Other Maintenance Workers	35,026		1,802							
8. Laundry Service										
a. Supervisor										
b. Other Laundry Workers	38,192		2,102							
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	131,989		2,110							
b. RN										
1. Direct Care	1,061,553		20,003							
2. Administrative**	478,496		8,830							
c. LPN										
1. Direct Care	657,603		17,721							
2. Administrative**										
d. Aides and Attendants	1,442,429		67,607							
e. Physical Therapists										
f. Speech Therapists										
g. Occupational Therapists										
h. Recreation Workers	122,013		5,170							
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	91,473		2,320							
n. Marketing										
o. Other (Specify) See Attached Schedule	64,927		2,038							
<i>A-13. Total Salary Expenditures</i>	<i>5,211,984</i>		<i>174,148</i>							

\* 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 of Other Salaries and Wages (Page 10)

Position	CCNH / RHNS			(Specify)			(Specify)		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
Admission Director Wages	\$ 64,927		2,038						
<b>Total</b>	\$ 64,927	\$ -	2,038	\$ -	\$ -	-	\$ -	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH / RHNS			(Specify)			(Specify)		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
<b>Total</b>	\$ -	\$ -	-	\$ -	\$ -	-	\$ -	\$ -	-



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

Name of Facility				License No.	Report for Year Ended			Page	of	
Colonial Health and Rehab Center of Plainfield, LLC				2387	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)							
<b>Section I - Operators/Owners</b>										
<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>										
Amber Darigan	104,524			Standard	Business Office Manager	2,368	A4			

\* 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	
Colonial Health and Rehab Center of Plainfield, LLC				2387	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)							
<b>Section III - Administrators***</b>										
Curtis Rodowicz	116,206			Standard	Administrator	1,960	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.

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

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

Name of Facility	License No.	Report for Year Ended						Page	of
Colonial Health and Rehab Center of Plainfield, LLC	2387	9/30/2023						13	37
Total Cost and Hours									
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>									
1. Dietitian	43,500		736						
2. Dentist	10,206		115						
3. Pharmacist	8,060		204						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	277,588		4,132						
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	36,000		216						
b. Utilization Review (Title 18 and 19 only) monthly meeting									
c. Resident Care**									
d. Administrative Services facility									
1. Infection Control Committee (Quarterly meetings)									
2. Pharmaceutical Committee (Quarterly meetings)									
3. Staff Development Committee (Once annually)									
e. Other (Specify) Physician	20,616		710						
9. Speech Therapist									
a. Resident Care	95,381		1,487						
b. Other									
10. Occupational Therapist									
a. Resident Care	282,251	(282,251)	4,714						
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care			130						
2. Administrative***	17,970								
b. LPN									
1. Direct Care	110,887		1,487						
2. Administrative***									
c. Aides	246,218		5,740						
d. Other									
12. Other (Specify) See Attached Schedule									
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>1,148,678</b>	<b>(282,251)</b>	<b>19,671</b>						

\* 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 Colonial Health and Rehab Center of Plainfield, LLC		License No. 2387		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				
HealthPro Therapy Service, LLC, 10600 York Road, Suite 105, Cockeysville, MD 21030	PT, ST, OT	<input type="radio"/>	<input checked="" type="radio"/>				
Healthdrive, 88 Worcester St, Wellesley, MA 02482	Dental Consultant	<input type="radio"/>	<input checked="" type="radio"/>				
Joseph Alessandro, D.O.	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>				
Pro Health Physicians, PO Box 150483, Hartford, CT 06115	Physician Fees	<input type="radio"/>	<input checked="" type="radio"/>				
Partners Pharmacy of CT, PO Box 9689, Uniondale, NY 11555	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>				
Maureen McCarthy	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>				
Alegiant Healthcare	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>				
RIAS Staffing	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>				
Covered Staffing LLC, 2385 NW Executive Center Dr, Suite 100, Boca Raton, FL 33431	Nursing Pool	<input checked="" type="radio"/>	<input 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"/>				
		<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
Colonial Health and Rehab Center of Plainfield, I	2387	9/30/2023					15	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
<b>I. Administrative and General</b>								
<b>a. Employee Health &amp; Welfare Benefits</b>								
1. Workmen's Compensation	\$ 173,827	173,827						
2. Disability Insurance	\$ 19,617	19,617						
3. Unemployment Insurance	\$ 43,880	43,880						
4. Social Security (F.I.C.A.)	\$ 409,743	409,743						
5. Health Insurance	\$ 1,426,208	1,426,208						
6. Life Insurance (employees only) (not-owners and not-operators)	\$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 535,064	535,064						
8. Uniform Allowance	\$ 19,256	19,256						
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 69,425	69,425	(1,126)					
<b>b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*</b>	\$							
<b>c. Bad Debts*</b>	\$ 36,000	36,000	(36,000)					
<b>d. Accounting and Auditing</b>	\$ 15,346	15,346						
<b>e. Legal (<i>Services should be fully described on Page 15b</i>)</b>	\$ 4,471	4,471						
<b>f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*</b>	\$ 11,996	11,996	(11,996)					
<b>g. Office Supplies</b>	\$ 25,598	25,598						
<b>h. Telephone and Cellular Phones</b>								
1. Telephone & Pagers	\$ 8,587	8,587						
2. Cellular Phones	\$							
<b>i. Appraisal (<i>Specify purpose and attach copy</i>)*</b>	\$							
<b>j. Corporation Business Taxes (<i>franchise tax</i>)</b>	\$ 219	219						
<b>k. Other Taxes (<i>Not related to property - See Page 22</i>)</b>								
1. Income*	\$							
2. Other ( <i>Specify</i> ) See Attached Schedule	\$ 1,445	1,445						
3. Resident Day User Fee	\$ 527,582	527,582						
<b>Subtotal</b>	\$ 3,328,264	3,328,264	(49,122)					

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

(Carry Subtotals forward to next page)

**Schedule of Other Employee Benefits**

<b>Description</b>	<b>CCNH / RHNS</b>	<b>Adjustment</b>	<b>(Specify)</b>	<b>Adjustment</b>	<b>(Specify)</b>	<b>Adjustment</b>
Other Employee Benefits	\$ 69,425	\$ (1,126)				
<b>Total</b>	\$ 69,425	\$ (1,126)	\$ -	\$ -	\$ -	\$ -

---

**Schedule of Other Taxes**

<b>Description</b>	<b>CCNH / RHNS</b>	<b>Adjustment</b>	<b>(Specify)</b>	<b>Adjustment</b>	<b>(Specify)</b>	<b>Adjustment</b>
Sales & Use Tax	\$ 1,445					
<b>Total</b>	\$ 1,445	\$ -	\$ -	\$ -	\$ -	\$ -

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**General Information and Questionnaire**  
**Accounting Basis**

Name of Facility Colonial Health and Rehab Center	License No. 2387	Report for Year Ended 9/30/2023	Page 15b	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

- Accrual     Cash     Modified Cash

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

**Independent Accounting Firm**

Name of Accounting Firm 1 CJLC LLC 2 3 4	Address (No. & Street, City, State, Zip Code) 225 Pitkin St., East Hartford, CT 06108
--	--

Services Provided by This Firm (*describe fully*)

1 Medicaid and Medicare Cost Report, Audited Financial Statements, and Tax Services	\$ 15,346
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 15,346

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

- Yes     No    15/1d

**Legal Services Information**

Name of Legal Firm or Independent Attorney 1 Murtha Cullina LLP 2 The Law Firm of Joseph Rodowicz LLC 3 Greystone Servicing Company 4 5	Telephone Number
--	------------------

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

1 PO Box 150435, Hartford, CT 06115
2 2235 NW Executive Center Drive, STE 100, Boca Raton, FL 33431
3 419 Belle Air Lane, Warrenton, VA 20186
4
5

Services Provided by This Firm (*describe fully*)

1 Health Regulatory & Survey IDR Review	\$ 512
2 Union Negotiations	\$ 1,459
3 DACA/DAISA Control Agreement	\$ 2,500
4	\$
5	\$
	Charge for Services Provided
	\$ 4,471

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

- Yes     No    15/1e

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

Name of Facility	License No.	Report for Year Ended					Page	of
Colonial Health and Rehab Center of Plainfield, LLC	2387	9/30/2023					16	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
<b>Subtotals Brought Forward:</b>	3,328,264	3,328,264	(49,122)					
<b>l. Travel and Entertainment</b>								
1. Resident Travel and Entertainment \$								
2. Holiday Parties for Staff \$	12,534	12,534						
3. Gifts to Staff and Residents \$								
4. Employee Travel \$	14	14						
5. Education Expenses Related to Seminars and Conventions \$	2,896	2,896						
6. Automobile Expense ( <i>not purchase or depreciation</i> ) \$								
7. Other ( <i>Specify</i> ) \$	1,465	1,465	(767)					
See Attached Schedule								
<b>m. Other Administrative and General Expenses</b>								
1. Advertising Help Wanted ( <i>all such expenses</i> ) \$	40,353	40,353						
2. Advertising Telephone Directory ( <i>all such expenses</i> )*** \$	2,504	2,504	(2,504)					
3. Advertising Other ( <i>Specify</i> )*** \$	26,970	26,970	(26,970)					
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 \$	6,207	6,207						
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) \$								
See Attached Schedule								
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.*** \$								
9. Subscriptions \$	15,038	15,038						
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> ) \$	12,759	12,759						
12. Administrative Management Services** \$	306,953	306,953	(128,712)					
13. Other ( <i>Specify</i> ) \$	89,774	89,774						
See Attached Schedule								
<b>C-14 Total Administrative &amp; General Expenditures</b>	<b>\$ 3,845,731</b>	<b>3,845,731</b>	<b>(208,075)</b>					

\* 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
Employee Travel	\$ 698					
Meals & Entertainment	\$ 767	\$ (767)				
<b>Total Other Travel and Entertainment</b>	<b>\$ 1,465</b>	<b>\$ (767)</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Community Awareness	\$ 26,970	\$ (26,970)				
<b>Total Other Advertising</b>	<b>\$ 26,970</b>	<b>\$ (26,970)</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

Schedule of Dues

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

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Background Checks	\$ 6,913					
Licenses and Permit Fees	\$ 1,523					
Bank Fees	\$ 8,109					
Software Maintenance	\$ 73,229					
<b>Total Other Administrative and General</b>	<b>\$ 89,774</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility	License No.	Report for Year Ended	Page of
Colonial Health and Rehab Center of Plainville	2387	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 #
Colonial Health & Rehab Management, LLC	178,241	Management Services	16/m12

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

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

Name of Facility		License No.	Report for Year Ended				Page	of
Colonial Health and Rehab Center of Plainfield, LLC		2387	9/30/2023				18	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	\$ 293,748	293,748						
2. Non-Food Supplies	\$ 33,844	33,844						
3. Other (Specify) _____	\$							
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$							
c. Other (Specify) _____	\$							
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 327,592</b>	<b>327,592</b>						
2E. Dietary Questionnaire		Total	CCNH / RHNS		(Specify)	(Specify)		
F. Resident Meals:	Total no. of meals served per day:*	3	3					
G. Is cost of employee meals included in 2D?	<input type="radio"/> Yes <input checked="" 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		License No.	Report for Year Ended				Page	of
Colonial Health and Rehab Center of Plainfield, LLC		2387	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. \$	10,128	10,128					
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$							
c. Other (Specify) Supplies	\$	7,554	7,554					
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	\$	17,683	17,683					
<b>3E. Laundry Questionnaire</b>								
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
Colonial Health and Rehab Center of Plainfield		2387	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. \$	27,893	27,893				
	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. \$	5,637	5,637				
	C. Other ( <i>Specify</i> )	\$						
4D.	<b>Total Housekeeping Expenditures</b> (4a + b + c)	\$	33,530	33,530				
5.	Resident Care (Supplies)**							
	a. Prescription Drugs***							
	1. Own Pharmacy	\$						
	2. Purchased from Prescription Drugs - Medicare A	\$	203,774	203,774	(203,774)			
	b. Medicine Cabinet Drugs	\$	21,297	21,297				
	c. Medical and Therapeutic Supplies	\$	186,389	186,389				
	d. Ambulance/Limousine***	\$	10,396	10,396	(10,396)			
	e. Oxygen							
	1. For Emergency Use	\$						
	2. Other***	\$	9,629	9,629	(9,629)			
	f. X-rays and Related Radiological Procedures***	\$	21,496	21,496	(21,496)			
	g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$						
	h. Laboratory***	\$	21,671	21,671	(21,671)			
	i. Recreation	\$	12,479	12,479				
	j. Direct Management Services*	\$						
	k. Indirect Management Services*	\$						
	l. Cable TV	\$	8,534	8,534				
	m. Other (Specify)**** See Attached Schedule	\$	33,444	33,444	(27,913)			
	n. Physical Therapy Expense	\$	2,122	2,122				
	o. Speech Therapy Expense	\$						
5P.	<b>Total Resident Care Expenditures</b> (5a - 5o)	\$	531,231	531,231	(294,879)			

\* 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.

Schedule of Other Resident Care

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
OT Supplies	\$ 1,773	\$ (1,773)				
Wound Care Medicare A	\$ 407	\$ (407)				
Wound Care Medicaid	\$ 84	\$ (84)				
Equipment Rental Wound Care	\$ 5,061	\$ (5,061)				
Equipment Rental over \$100	\$ 5,531					
IV Therapy Consult	\$ 507	\$ (507)				
IV Supplies	\$ 6,533	\$ (6,533)				
IV Solution	\$ 13,749	\$ (13,749)				
Resident Expense	\$ (201)	\$ 201				
<b>Total Other Resident Care</b>	\$ 33,444	\$ (27,913)	\$ -	\$ -	\$ -	\$ -

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

Name of Facility Colonial Health and Rehab Center of Plainfield, LLC			License No. 2387		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
Healthcare Services Group, Inc.	3220 Tillman Drive, Bansalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		Dietary Services	43,500			13	b1
Healthcare Services Group, Inc.	3220 Tillman Drive, Bansalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		Housekeeping Services	5,637			20	4b
Point Click Care	Unit 4, Mississauga, Ontario Canada 109178-	<input type="radio"/>	<input checked="" type="radio"/>		Software Provider	73,229			16	m13
		<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"/>							
		<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
Colonial Health and Rehab Center of Plainfield	2387	9/30/2023					22	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	\$ 94,281	94,281						
b. Heat	\$ 51,681	51,681						
c. Light & Power	\$ 134,187	134,187						
d. Water	\$ 23,514	23,514						
e. Equipment Lease ( <i>Provide detail on page 22b</i> )	\$ 3,999	3,999						
f. Other ( <i>itemize</i> )	\$ 42,052	42,052						
See Attached Schedule								
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	\$ 349,713	349,713						
7. Depreciation ( <i>complete schedule page 23*</i> )								
a. Land Improvements	\$							
b. Building & Building Improvements	\$							
c. Non-Movable Equipment	\$ 22,717	22,717						
d. Movable Equipment	\$ 34,950	34,950						
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	\$ 57,667	57,667						
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )								
a. Organization Expense	\$							
b. Mortgage Expense	\$							
c. Leasehold Improvements	\$ 11,389	11,389						
d. Other ( <i>Specify</i> )	\$							
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	\$ 11,389	11,389						
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 685,910	685,910						
10. Property Taxes								
a. Real estate taxes paid by owner	\$							
b. Real estate taxes paid by lessor	\$ 86,099	86,099						
c. Personal property taxes	\$ 12,088	12,088						
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	\$ 853,153	853,153						

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



Schedule of Other Repairs and Maintenance

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Plant Garbage	\$ 31,603					
Equipment Rental	\$ 10,449					
<b>Total Other Repairs and Maintenance</b>	\$ 42,052	\$ -	\$ -	\$ -	\$ -	\$ -

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### General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility Colonial Health and Rehab Center of Plainfield, LLC			License No. 2387	Report for Year Ended 9/30/2023			Page 22b	of 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						
Xerox Financial Services LLC, 201 Merritt 7, Norwalk, CT 06851	<input type="radio"/>	<input checked="" type="radio"/>	Copier	04/01/21	3 years	3,999	3,999	
	<input checked="" type="radio"/>	<input 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"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes <input type="radio"/> No	<b>Total ***</b>
							3,999	

\* 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.

### Depreciation Schedule

Name of Facility Colonial Health and Rehab Center of Plainfield, LLC			License No. 2387		Report for Year Ended 9/30/2023			Page 23	of 37				
Property Item			Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals			
<b>A. Land Improvements</b>													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal													
<b>B. Building and Building Improvements</b>													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal													
<b>C. Non-Movable Equipment</b>													
1. Acquired prior to this report period			596,223		596,223	274,175	SL	Var	21,188				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			49,872						1,530				
C-4. Subtotal										22,718			
		Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
		Yes	No	Month	Year								
<b>D. Movable Equipment</b>													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a.													
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period					Var	Var	782,567	782,567	709,456	SL	Var	31,982	
b. Disposals (attach schedule)													
Acquired during this report period (attach schedule):													
c. Administrative							21,516					2,482	
d. Standard Resident							4,853					485	
e. Specialized Resident													
Total Acquired during this report period							26,369					2,967	
D-3. Subtotal													34,949
<b>E. Total Depreciation</b>													57,667

Schedule of Land Improvements Acquired during this report period

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

\*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
<b>Additions:</b>				
<b>Total additions for Building Improvements</b>		\$ -		\$ -
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$ -		\$ -

\*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
<b>Additions:</b>				
2/7/2023	Hot Water Heater	\$ 6,937	10	\$ 578
3/9/2023	Fire Sprinkler Repairs	\$ 3,269	15	\$ 127
3/10/2023	Sprinkler Pipe Replacement	\$ 3,185	15	\$ 124
5/31/2023	Water Heater Replacement	\$ 3,681	10	\$ 154
8/17/2023	Dryer	\$ 8,612	10	\$ 144
8/17/2023	Washer	\$ 20,958	10	\$ 349
8/30/2023	3 Mage Lock	\$ 3,230	10	\$ 54
<b>Total additions for Non-Movable Equipment</b>		\$ 49,872		\$ 1,530
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ -

\*Ties to Page 23, Line C3

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>					
10/20/2022	Direct Supply	Administrative	\$ 851	5	\$ 170
10/26/2022	HEPA Air Filters	Administrative	\$ 3,206	5	\$ 641
3/30/2023	Vital Sign Monitor	Administrative	\$ 2,517	5	\$ 294
4/12/2023	Bariatric Hoyer	Standard Resident	\$ 4,853	5	\$ 485
4/27/2023	Linen Cart	Administrative	\$ 7,913	5	\$ 791
7/31/2023	Lenovo Laptop; 1 Thinksystem ST550	Administrative	\$ 7,028	5	\$ 586
<b>Total additions for Movable Equipment</b>			\$ 26,369		\$ 2,967
<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
12/8/2022	Carpet	\$ 16,571	15	\$ 921
9/29/2023	Roof	\$ 133,921	20	\$ 558
<b>Total additions for Leasehold Improvement</b>		\$ 150,492		\$ 1,479
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ -

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

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

**Amortization Schedule\***

Name of Facility			License No.		Report for Year Ended			Page	of
Colonial Health and Rehab Center of Plainfield, LLC			2387		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							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period	Var	Var	Var	1,069,888	161,507	SL	Var	9,910	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				150,492				1,479	
C-4. Subtotal									11,389
<b>D. Total Amortization</b>									11,389

\* 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 Colonial Health and Rehab Center of H	License No. 2387	Report for Year Ended 9/30/2023	Page 25	of 37
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11. Property Questionnaire

**Part A**

Is the property either owned by the Facility or leased from a Related Party?\*

Yes  No

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

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

Description	Total			
1. Date Land Purchased				
2. Date Structure Completed				
3. If <b>NOT</b> Original Owner, Date of Purchase	12/29/12			
4. Date of Initial Licensure	07/13/83			
5. Total Licensed Bed Capacity	90			
6. Square Footage	37,000			
7. Acquisition Cost				
a. Land				
b. Building				

**Part B - Owner and Related Parties**

1st Mortgage    2nd Mortgage    3rd Mortgage    4th Mortgage

1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>				
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				Page	of
Colonial Health and Rehab Center of		2387	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		\$						
Name of Lender		Rate						
Address of Lender								
2. Second Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
3. Third Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
4. Fourth Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
B. CHEFA Loan Information								
1. Original Loan Amount		\$						
2. Loan Origination Date								
3. Interest Rate %								
4. Term								
5. CHEFA Interest Expense								
12 B7. <b>Total Building Interest Expense</b> (A1 - A4 + B5)		\$						

(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	
Colonial Health and Rehab Center		2387		9/30/2023				27	37	
Item				Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:										
12. C. Movable Equipment										
1. Automotive Equipment				\$						
A. Item		Rate	Amount							
Lender										
Address of Lender										
2. Other (Specify)				\$						
A. Item		Rate	Amount							
Lender										
Address of Lender										
B. Item		Rate	Amount							
Lender										
Address of Lender										
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$						
12. D. Other Interest Expense (Specify) Finance Interest				\$	674	674				
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	674	674				
14. Insurance										
a. Insurance on Property (buildings only)				\$	89,195	89,195				
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)				\$	89,195	89,195				
15. Total All Expenditures (A-13 thru C-14)				\$	12,409,164	12,409,164	(785,205)			

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended		Page	of
Colonial Health and Rehab Center of Plai	2387	9/30/2023		30	37
Item	Total	CCNH / RHNS	(Specify)	(Specify)	
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 8,396,219	8,396,219			
b. Medicaid Room and Board Contractual Allowance **	\$ (1,537,928)	(1,537,928)			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 396,982	396,982			
b. Medicare Room and Board Contractual Allowance **	\$ 1,105,869	1,105,869			
4. a. Private-Pay Residents and Other	\$ 1,927,971	1,927,971			
b. Private-Pay Room and Board Contractual Allowance **	\$ (789,908)	(789,908)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 166,762	166,762			
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$ 101,540	101,540			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$				
2. a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$ 1,221,675	1,221,675			
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$ 549,300	549,300			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$ 204,450	204,450			
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$ 109,350	109,350			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$ 1,127,575	1,127,575			
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$ 599,450	599,450			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other ( <i>Specify</i> ) - Medicare	\$ (1,652,427)	(1,652,427)			
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 7,610	7,610			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 11,934,491	11,934,491			
<b>IV. Other Revenue*</b>					
1. Meals sold to guests, employees & others	\$ 0	0			
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income ( <i>Specify</i> )	\$ 1,832	1,832			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 15,711	15,711			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 17,543	17,543			
<b>VI. Total All Revenue</b> (III +V)	\$ 11,952,034	11,952,034			

\* 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)
30/II6a	X-Ray-Medicare A	\$ 13,540		
30/II6a	Lab Revenue-Medicare A	\$ 14,429		
30/II6a	Contractual Allow-Med A Ancill	\$ (1,086,545)		
30/II6a	Contractual Allow-Med B	\$ (590,514)		
30/II6a	Contractual Allow-Med B Seq 2%	\$ (3,337)		
<b>Total Other Resident Revenue - Medicare</b>		\$ (1,652,427)	\$ -	\$ -

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

**Related Exp**

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
30/II6b	X-Ray Medicaid	\$ 106		
30/II6b	X-Ray Managed Care	\$ 5,155		
30/II6b	Lab Revenue Managed Care	\$ 2,353		
30/II6b	Lab Revenue-Medicaid	\$ (4)		
<b>Total Other Resident Revenue</b>		\$ 7,610	\$ -	\$ -

**Interest Income**

Page Ref	Account	Account Balance	CCNH / RHNS	(Specify)	(Specify)
30/IV5	Interest Income		\$ 1,832		
<b>Total Interest Income</b>			\$ 1,832	\$ -	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
30/IV8	Miscellaneous Income	\$ 15,711		
<b>Total Other Revenue</b>		\$ 15,711	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health and Rehab Center of P	2387	9/30/2023	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	722,483
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	833,339
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	70,263
a. _____				
b. _____				
c. _____				
d. See Schedule		70,263		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	230,071
_____				
_____				
See Schedule		230,071		
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	1,856,156
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
4. Leasehold Improvements	*Historical Cost <u>1,220,380</u>		\$	1,047,484
	Accum. Depreciation <u>172,895</u>	Net		
5. Non-Movable Equipment	*Historical Cost <u>646,096</u>		\$	349,203
	Accum. Depreciation <u>296,893</u>	Net		
6. Movable Equipment	*Historical Cost <u>808,935</u>		\$	64,527
	Accum. Depreciation <u>744,408</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	(887,124)
_____				
See Schedule		(887,124)		
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	574,090

\* 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	
31	A5	Prepaid Insurance	\$ 22,450
31	A5	Prepaid Expenses (Other)	\$ 12,259
31	A5	Prepaid Real Estate Taxes	\$ 32,971
31	A5	Prepaid Personal Property Taxes	\$ 2,583
<b>Total Prepaid Expenses</b>			<b>\$ 70,263</b>

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

Page Ref	Line Ref	Description	
31	A8	HUD Tax	\$ 18,858
31	A8	HUD Insurance	\$ 66,346
31	A8	HUD Replacement Reserves	\$ 107,660
31	A8	HUD Mortgage Insurance Protect	\$ 37,207
<b>Total Other Current Assets (Itemize)</b>			<b>\$ 230,071</b>

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

Page Ref	Line Ref	Description	
31	B9	Capitalized Finance Costs	\$ 64,240
31	B9	Accum Amort Finance Costs	\$ (64,240)
31	B9	Book Vs Cost	\$ (887,124)
<b>Total Other Other Fixed Assets (Itemize)</b>			<b>\$ (887,124)</b>

Schedule of Other Assets Page 32 Line D7

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

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
<b>Total Notes Payable</b>			<b>\$ -</b>

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

Page Ref	Line Ref	Description	
33	A12	Advance Payments To Facility	\$ 120,402
33	A12	401K/Pension/Health	\$ 1
33	A12	Union PAC Withheld	\$ 716
33	A12	Union Dues Withheld	\$ 225
33	A12	HAS ER Contribution	\$ (3,158)
33	A12	HSA EE Contribution	\$ (130)
33	A12	HRA	\$ 567,124
33	A12	EBHRA	\$ 25,250
33	A12	Capital Lease Payable	\$ (2)
33	A12	American Express	\$ 12,090
<b>Total Other Current Liabilities (Itemize)</b>			<b>\$ 722,517</b>

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

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

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

Name of Facility Colonial Health and Rehab Center of Pl	License No. 2387	Report for Year Ended 9/30/2023	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$ 2,430,246	
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 <b>Total Leasehold or Like Properties</b> (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense			\$	
*Historical Cost _____				
Accum. Depreciation _____			Net	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care ( <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> )			\$	
_____				
_____				
See Schedule				
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$ 2,430,246	

\* 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
Colonial Health and Rehab Center of Plainfield		2387	9/30/2023	33	37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	1,386,953
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> )				\$	300,837
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	7,862
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable ( <i>Current Portion</i> )				\$	
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities ( <i>itemize</i> )				\$	722,517
_____					
_____					
_____					
See Schedule				722,517	
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>				\$	<b>2,418,169</b>

\* 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 Colonial Health and Rehab Center of Plainf	License No. 2387	Report for Year Ended 9/30/2023		Page 34	of 37
Account				Amount	
Total Brought Forward:				2,418,169	
<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				\$	
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$	
Name and Address of Lender	Amount	Loan Date			
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$	
_____					
_____					
See Schedule					
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 2,418,169	



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

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health and Rehab Center of I	2387	9/30/2023	35	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			\$	(2,812,908)
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	3,282,114
6. Gain or Loss for Period			\$	(457,131)
	10/1/2022	thru	9/30/2023	
7. Total Net Worth			\$	12,076
<b>C. Total Reserves and Net Worth</b>			\$	12,076
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	2,430,245

### H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health and Rehab Center of Pla	2387	9/30/2023	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2022			\$	3,396,125
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	11,952,034
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	12,409,164
D. Net Income or Deficit			\$	(457,131)
E. Balance			\$	2,938,994
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	
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. <b>Balance at End of Period</b>			\$	2,938,994
				09/30/23

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

Name of Facility Colonial Health and Rehab Center of	License No. 2387	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)		
<b>Preparer/Reviewer Certification</b>				
<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				
CJLC LLC				
Address Address		Phone Number		
225 Pitkin St., East Hartford, CT 06108		860-610-9009		
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number		
CJLC		860-610-9009		
Contact Email Address				
annualreports@cjlc.com				