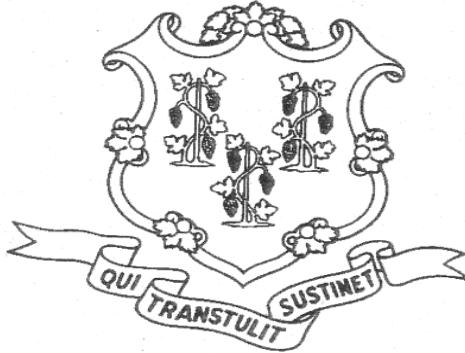


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2021

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 only (CCNH)		Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)		
Report for Year Beginning 10/1/2020		Report for Year Ending 9/30/2021		

License Numbers:	CCNH 2387	RHNS	(Specify)	Medicare Provider 2387
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Medicaid Provider Numbers:	CCNH 07-5310	RHNS	ICF-IID
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For Department Use Only

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

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General Information

Name of Facility (as licensed) Colonial Health and Rehab Center of Plainfield, LLC	License No. 2387	Report for Year Ended 9/30/2021	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 Colonial Health and Rehab Center of Plainfield, LLC [facility name], for the cost report period beginning October 1, 2020 and ending September 30, 2021, 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 Heath & 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

Data Required for Real Wage Adjustment				Page 1A	of 37
Name of Facility Colonial Health and Rehab Center of Plainfield, LLC	Period Covered:	From 10/1/2020	To 9/30/2021		
Address of Facility 16 Windsor Ave Plainfield, CT 06374					
Report Prepared By CJLC LLC	Phone Number 860-610-9009	Date 1/27/2022			
Item	Total	CCNH	RHNS	(Specify)	
1. Dietary wages paid	\$				
2. Laundry wages paid	\$				
3. Housekeeping wages paid	\$				
4. Nursing wages paid	\$				
5. All other wages paid	\$				
6. Total Wages Paid	\$				
7. Total salaries paid	\$				
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-564-4081	9/30/2021	2	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 2387	RHNS	(Specify)	Medicare Provider No. 2387
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input 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.

Administrator		
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 Partners/Members

General Information and Questionnaire

Corporate Owners

Name of Facility Colonial Health and Rehab Center of Plainfield	License No. 2387	Report for Year Ended 9/30/2021	Page 3A	of 37
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If this facility is owned or operated as a corporation, provide the following information:

State of Connecticut

Annual Report of Long-Term Care Facility

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General Information and Questionnaire
Individual Proprietorship

Name of Facility Colonial Health and Rehab Center of Plainfield, LLC	License No. 2387	Report for Year Ended 9/30/2021	Page of 3B 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

N/A

General Information and Questionnaire

Related Parties*

Name of Facility Colonial Health and Rehab Center of Plainfield, LLC	License No. 2387	Report for Year Ended 9/30/2021			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input checked="" type="radio"/> Yes <input type="radio"/> No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.				
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?				<input checked="" type="radio"/> Yes <input type="radio"/> No If "Yes," provide the following information:				
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			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 Heath & Rehab Management LLC	2385 NW Executive Center Dr., Boca Raton, FL 33431	<input type="radio"/>	<input checked="" type="radio"/>		Management Services	16/m12	535,780	535,780
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	637,689	637,689
Covered Staffing LLC	2385 NW Executive Center Dr., Suite 100, Boca Raton, FL 33431	<input type="radio"/>	<input checked="" type="radio"/>		Nursing Pool	13/11c	10,421	10,421
		<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 Colonial Health and Rehab Center of Plainfield	License No. 2387	Report for Year Ended 9/30/2021	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.

General Information and Questionnaire Leases (Excluding Real Property)

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

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes

○ No

Total ***

3,254

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

** Attach copies of newly acquired leases.

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

General Information and Questionnaire Accounting Basis

Name of Facility Colonial Health and Rehab Center	License No. 2387	Report for Year Ended 9/30/2021	Page 7	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	\$	14,196
2		\$	
3		\$	
4		\$	
		Charge for Services Provided	
		\$	14,196

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

Yes No | Pg 15/1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Michelson, Kane, Royster & Barger, P.C.	
2 Murtha Cullina LLP	
3 The Law Firm of Joseph Rodowicz LLC	
4	
5	

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

1 Ten Columbus Blvd, Hartford, CT 06106
2 PO Box 150435, Hartford CT 06115
3
4
5

Services Provided by This Firm (*describe fully*)

1	Rodowicz vs Rodowicz, Darigan	\$	11,365
2	Labor, Health Regulatory, IDR 2/17/21	\$	5,029
3	4/26/21-Deposition Natasha Haskell Defense (Settled Nov 2021)	\$	984
4		\$	
5		\$	
		Charge for Services Provided	
		\$	17,378

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

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Schedule of Resident Statistics

Name of Facility Colonial Health and Rehab Center of Plainfield, LLC			License No. 2387				Report for Year Ended 9/30/2021				Page 8 of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity					90	90			90	90		
A. On last day of PREVIOUS report period	90	90										
B. On last day of THIS report period	90	90			90	90			90	90		
2. Number of Residents					78	78			85	85		
A. As of midnight of PREVIOUS report period	78	78										
B. As of midnight of THIS report period	83	83			85	85			83	83		
3. Total Number of Days Care Provided During Period					3,444	3,444			925	925		
A. Medicare	4,369	4,369										
B. Medicaid (Conn.)	19,683	19,683			13,841	13,841			5,842	5,842		
C. Medicaid (other states)												
D. Private Pay	3,071	3,071			2,375	2,375			696	696		
E. State SSI for RCH												
F. Other (Specify) Managed Care	1,613	1,613			1,305	1,305			308	308		
G. Total Care Days During Period (3A thru F)	28,736	28,736			20,965	20,965			7,771	7,771		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds					11	11			11	11		
A. Medicaid Bed Reserve Days	22	22										
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	28,758	28,758			20,976	20,976			7,782	7,782		

Schedule of Resident Statistics (Cont'd)

Name of Facility Colonial Health and Rehab Center of Plainfield			License No. 2387			Report for Year Ended 9/30/2021			Page 9	of 37	
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:											
Date of Change	Place of Change			Change in Beds				Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost		Gained		CCNH	RHNS	(Specify)	
(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)			
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.											
Change in Resident Days								CCNH	RHNS	(Specify)	
								1st change			
2nd change											
3rd change											
4th change											
6. Number of Residents and Rates on September 30 of Cost Year											
Item	Medicare		Medicaid		Self-Pay			Other State Assisted			
	CCNH	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR		
No. of Residents	13	60		10							
Per Diem Rate											
a. One bed rm.	RUGS	253.00		405.00							
b. Two bed rms.		251.00		385.00							
c. Three or more bed rms.											
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)
								5,765	5,765		
A. Medicare - Part B											
B. Medicaid (Exclusive of Part B)											
1. Maintenance Treatments											
2. Restorative Treatments								1	1		
C. Other								3,714	3,714		
D. Total Physical Therapy Treatments								9,480	9,480		
8. Total Number of Speech Therapy Treatments											
A. Medicare - Part B								697	697		
B. Medicaid (Exclusive of Part B)											
1. Maintenance Treatments											
2. Restorative Treatments											
C. Other								263	263		
D. Total Speech Therapy Treatments								960	960		
9. Total Number of Occupational Therapy Treatments											
A. Medicare - Part B								2,873	2,873		
B. Medicaid (Exclusive of Part B)											
1. Maintenance Treatments											
2. Restorative Treatments								33	33		
C. Other								3,365	3,365		
D. Total Occupational Therapy Treatments								6,271	6,271		

Report of Expenditures - Salaries & Wages

Name of Facility Colonial Health and Rehab Center of Plainfield, LLC	License No. 2387	Report for Year Ended 9/30/2021	Page 10	of 37		
Are time records maintained by all individuals receiving compensation?	<input checked="" type="radio"/> Yes			<input type="radio"/> No		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	116,389	2,240				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	218,459	7,356				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	302,108	16,290				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	223,845	8,535				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	62,196	2,150				
b. Other Maintenance Workers	34,886	1,751				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	37,829	4,052				
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	124,579	2,544				
b. RN						
1. Direct Care	627,431	12,256				
2. Administrative**	349,261	9,290				
c. LPN						
1. Direct Care	803,073	24,174				
2. Administrative**						
d. Aides and Attendants	1,333,872	69,504				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	126,584	5,133				
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	43,541	1,698				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	64,813	2,053				
<i>A-13. Total Salary Expenditures</i>	<i>4,468,866</i>	<i>169,024</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 on Page 28.

Schedule of Other Salaries and Wages (Page 10)

Schedule of Other Fees (Page 13)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-11 Rev. 10/2005

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

Name of Facility Colonial Health and Rehab Center of Plainfield, LLC				License No. 2387		Report for Year Ended 9/30/2021			Page 11	of 37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
Amber Darigan	94,421			Standard	Business Office Manager	2,240	A4			
Deborah Rodowicz	33,361			Collective Bargaining	CNA	1,592	A12d			

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

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

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page	of
Colonial Health and Rehab Center of Plainfield, LLC				2387		9/30/2021			12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Curtis Rodowicz	116,389			Standard	Administrator	2,240	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
	2387	9/30/2021		13	37
	Total Cost and Hours				
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)					
1. Dietitian					
2. Dentist	10,206	Contract			
3. Pharmacist	8,485	169			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	405,857	6,950			
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	36,000	217			
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) Medical Staff	7,873	Contract			
9. Speech Therapist					
a. Resident Care	90,512	1,395			
b. Other					
10. Occupational Therapist					
a. Resident Care	318,855	5,213			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	16,609	110			
2. Administrative***		32			
b. LPN					
1. Direct Care	25,496	291			
2. Administrative***					
c. Aides	47,423	742			
d. Other					
12. Other (Specify)					
See Attached Schedule					
B-13 Total Fees Paid in Lieu of Salaries	967,316	15,120			

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

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

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

Report of Expenditures

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

* 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
		9/30/2021		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$	119,006	119,006		
2. Disability Insurance	\$	16,353	16,353		
3. Unemployment Insurance	\$	55,053	55,053		
4. Social Security (F.I.C.A.)	\$	341,597	341,597		
5. Health Insurance	\$	714,879	714,879		
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$	240,568	240,568		
8. Uniform Allowance	\$	6,423	6,423		
9. Other (Specify) See Attached Schedule	\$	90,017	90,017		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$	36,000	36,000		
d. Accounting and Auditing	\$	14,196	14,196		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$	17,378	17,378		
f. Insurance on Lives of Owners and Operators (Specify)*	\$	11,996	11,996		
g. Office Supplies	\$	23,912	23,912		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	6,586	6,586		
2. Cellular Phones	\$				
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$	(31,364)	(31,364)		
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (Specify) See Attached Schedule	\$	2,259	2,259		
3. Resident Day User Fee	\$	530,757	530,757		
Subtotal	\$	2,195,615	2,195,615		

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

(Carry Subtotals forward to next page)

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

Colonial Health and Rehab Center of Plainfield, LLC
9/30/2021

Attachment Page 15

Schedule of Other Employee Benefits

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Sales & Use Tax	\$ 2,259		
Total	\$ 2,259	\$ -	\$ -

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

Name of Facility Colonial Health and Rehab Center of Plainfield, LLC	License No. 2387	Report for Year Ended 9/30/2021		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
	<i>Subtotals Brought Forward:</i>	2,195,615	2,195,615		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	8,791	8,791		
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	26	26		
5. Education Expenses Related to Seminars and Conventions	\$	1,807	1,807		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$	6,180	6,180		
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	42,241	42,241		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$	666	666		
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	23,890	23,890		
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$	5,771	5,771		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	5,082	5,082		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	650	650		
9. Subscriptions	\$	6,552	6,552		
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>)	\$	18,447	18,447		
12. Administrative Management Services**	\$	535,780	535,780		
13. Other (<i>Specify</i>) See Attached Schedule	\$	102,480	102,480		
C-14 Total Administrative & General Expenditures	\$	2,953,978	2,953,978		

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

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Meal & Entertainment	\$ 3,293		
Employee Meals	\$ 2,888		
Total Other Travel and Entertainment	\$ 6,180	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Community Awarness	\$ 23,890		
Total Other Advertising	\$ 23,890	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 4,772		
ACHA	\$ 310		
Total Dues	\$ 5,082	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Background Checks	\$ 6,700		
License & Permit Fees	\$ 2,100		
Bank Fees	\$ 11,675		
Software Maintenance	\$ 82,005		
Total Other Administrative and General	\$ 102,480	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Colonial Health and Rehab Center of Plainfield	License No. 2387	Report for Year Ended 9/30/2021	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Colonial Heath & Rehab Management, LLC	535,780	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 Colonial Health and Rehab Center of Plainfield, LLC	License No. 2387	Report for Year Ended 9/30/2021		Page 18 of 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 217,302	217,302		
2. Non-Food Supplies	\$ 26,058	26,058		
3. Other (Specify) _____	\$ _____			
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ 138,899	138,899		
c. Other (Specify) _____	\$ _____			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 382,259	382,259		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	86,274	86,274		
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 checked="" type="radio"/> Yes <input type="radio"/> No				If yes, specify cost.
K. Is any revenue collected from these people? <input checked="" type="radio"/> Yes <input type="radio"/> No				If yes, specify amt. \$366
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				30/IV1
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 Colonial Health and Rehab Center of Plainfield, LLC	License No. 2387	Report for Year Ended 9/30/2021		Page 19	of 37
Item	Total	CCNH	RHNS	(Specify)	
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. \$				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. \$				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. \$	16,231	16,231		
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$				
c. Other (<i>Specify</i>) Supplies	\$	4,182	4,182		
3D. Total Laundry Expenditures (3a + b + c)	\$	20,413	20,413		
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 Colonial Health and Rehab Center of Plainfield	License No. 2387	Report for Year Ended 9/30/2021		Page 20	of 37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 20,421	20,421		
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)					
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel				
	Amt.	\$ 7,551	7,551		
C. Other (<i>Specify</i>)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	27,971	27,971		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Prescribed Drugs - Medicare A	\$	212,955	212,955		
b. Medicine Cabinet Drugs	\$	19,396	19,396		
c. Medical and Therapeutic Supplies	\$	402,953	402,953		
d. Ambulance/Limousine***	\$	7,859	7,859		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	7,891	7,891		
f. X-rays and Related Radiological Procedures***	\$	27,658	27,658		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	25,019	25,019		
i. Recreation	\$	3,965	3,965		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (Specify)**** See Attached Schedule	\$	26,800	26,800		
5M. Total Resident Care Expenditures (5a - 5j)	\$	734,495	734,495		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
PT Supplies	\$ 1,607		
OT Supplies	\$ 1,287		
IV therapy consult	\$ 407		
IV Supplies	\$ 5,636		
IV Solution	\$ 717		
Equipment Rental Wound Care	\$ 8,444		
Equipment over \$100	\$ 350		
Cable Television / Internet	\$ 9,471		
Resident Expense	\$ (1,119)		
Total Other Resident Care	\$ 26,800	\$ -	\$ -

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

* 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 Colonial Health and Rehab Center of Plainfiel	License No. 2387	Report for Year Ended 9/30/2021			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	88,442	88,442			
b. Heat	\$	41,446	41,446			
c. Light & Power	\$	93,088	93,088			
d. Water	\$	21,005	21,005			
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$	3,254	3,254			
f. Other (<i>itemize</i>)	\$	41,890	41,890			
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	289,125	289,125			
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$	12,849	12,849			
d. Movable Equipment	\$	55,007	55,007			
*7e. Total Depreciation Costs (7a + b + c + d)	\$	67,855	67,855			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$	3,208	3,208			
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$	3,208	3,208			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	637,689	637,689			
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	95,656	95,656			
c. Personal property taxes	\$	12,175	12,175			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	816,583	816,583			

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

Colonial Health and Rehab Center of Plainfield, LLC
9/30/2021

Attachment Page 22

Schedule of Other Repairs and Maintenance

Depreciation Schedule

Colonial Health and Rehab Center of Plainfield, LLC
9/30/2021

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

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Total deletions for Non-Movable Equipment	\$	-	\$	-	** Attachment Pages 23 24
--	----	---	----	---	---------------------------

*Ties to Page 23, Line C3
**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
11/2/2020	Direct Supply - vital sign monitor & Stand	\$ 1,117	5	\$ 205
11/3/2020	Direct Supply - vital sign tablet and mount bracket	\$ 692	5	\$ 127
11/2/2020	Direct Supply - 20i floor burnisher	\$ 1,941	5	\$ 356
11/19/2020	HD Supply Facilities Maintenance LTD - Tilt Truck & Dome lid	\$ 888	5	\$ 163
11/23/2020	Hill-Rom - 2 Sabina Mobile Lift	\$ 9,790	5	\$ 1,795
11/20/2020	The Home Depot Pro - Victory Hand Sprayer - COVID Cleaning	\$ 719	5	\$ 132
1/8/2021	Direct Supply - Food Delivery Cart	\$ 5,171	5	\$ 776
3/1/2021	Direct Supply - O2 Concentrators	\$ 1,184	5	\$ 138
3/19/2021	Wells Fargo - Copier Lease Buyout	\$ 3,254	5	\$ 380
4/15/2021	Amazon - Rug Doctor Machine	\$ 591	5	\$ 59
5/18/2021	Vitality - Mannequin for Staff Education	\$ 1,971	5	\$ 164
9/15/2021	JKS Systems - 5 laptops	\$ 5,466	3	\$ 152
9/7/2021	Direct Supply - Air Mattress Replacement Pumps	\$ 1,995	5	\$ 33
Total additions for Movable Equipment		\$ 34,779		\$ 4,479 *
Deletions:				
Total deletions for Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
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 Colonial Health and Rehab Center of Plainfield, LLC			License No. 2387		Report for Year Ended 9/30/2021			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period	Var	Var	Var	935,843	148,389	SL	VAR	3,208	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									3,208
D. Total Amortization									3,208

* Straight-line method must be used.

** Specify which of the following bases were used:

- Minimum of 5 years or 60 months.
- Life of mortgage; OR
- Remaining Life of Lease; OR
- 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 I	License No. 2387	Report for Year Ended 9/30/2021	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					
3. If NOT 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					
Complete if Mortgage was Refinanced During Current Cost Year					
g. Type of Financing (e.g., fixed, variable)					
h. Date of Refinancing					
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed					
l. Principal Outstanding on Note Paid-Off					
Part C - Arms-Length Leases for Real Property Improvements Only					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	

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

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

Name of Facility	License No.	Report for Year Ended 9/30/2021			Page 26	of 37
Item		Total	CCNH	RHNS	(Specify)	
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
2. Second Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
3. Third Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
4. Fourth Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount		\$				
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$				

(Carry Subtotals forward to next page)

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	9/30/2021			27	37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		\$				
12. D. Other Interest Expense (Specify)		\$	1,253	1,253		
Vendor and Finance Interest						
13. Total All Interest Expense (12B7 + 12C3 + 12D)		\$	1,253	1,253		
14. Insurance						
a. Insurance on Property (buildings only)		\$	92,830	92,830		
b. Insurance on Automobiles		\$	750	750		
c. Insurance other than Property (as specified above)						
1. Umbrella (<i>Blanket Coverage</i>)		\$				
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$				
14d. Total Insurance Expenditures (14a + b + c)		\$	93,580	93,580		
15. Total All Expenditures (A-13 thru C-14)		\$	10,755,839	10,755,839		

D. Adjustments to Statement of Expenditures

Name of Facility Colonial Health and Rehab Center of Plainfield, LLC			License No. 2387	Report for Year Ended 9/30/2021		Page 28 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS (Specify)
Page 10 - Salaries and Wages						
1.			Outpatient Service Costs	\$		
2.			Salaries not related to Resident Care	\$		
3.			Occupational Therapy	\$		
4.			Other - See attached Schedule	\$		
Page 13 - Professional Fees						
5.			Resident Care Physicians **	\$		
6.	13	b10a	Occupational Therapy	\$ 318,855	318,855	
7.			Other - See attached Schedule	\$		
Pages 15 & 16 - Administrative and General						
8.			Discriminatory Benefits	\$		
9.	15	1c	Bad Debts	\$ 36,000	36,000	
10.			Accounting	\$		
10a.			Legal	\$ 11,365	11,365	
11.			Telephone	\$		
12.			Cellular Telephone	\$		
13.	15	1f	Life insurance premiums on the life of Owners, Partners, Operators	\$ 11,996	11,996	
14.			Gifts, flowers and coffee shops	\$		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$		
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$		
17.			Automobile Expense (e.g. personal use)	\$		
18.	16	m2/m	Unallowable Advertising *	\$ 24,556	24,556	
19.	15	1j/k2	Income Tax / Corporate Business Tax	\$ 2,259	2,259	
20.			Fund Raising / Contributions	\$		
21.			Unallowable Management Fees	\$		
22.			Barber and Beauty	\$		
23.			Other - See attached Schedule	\$ 3,943	3,943	
Page 18 - Dietary Expenditures						
24.	30	IV8	Meals to employees, guests and others who are not residents	\$ 366	366	
Page 19 - Laundry Expenditures						
25.			Laundry services to employees, guests and others who are not residents	\$		
Page 20 - Housekeeping Expenditures						
26.			Housekeeping services to employees, guests and others who are not residents	\$		
Subtotal (Items 1 - 26)			\$ 409,340	409,340		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	17	Meals & Entertainment	\$ 3,293		
16	m8a	Chamber of Commerce	\$ 650		
Total Other A&G Adjustments			\$ 3,943	\$ -	\$ -

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-29 Rev. 10/2006

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

Name of Facility Colonial Health and Rehab Center of Plainfield, LLC				License No. 2387	Report for Year Ended 9/30/2021		Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)	
Subtotals Brought Forward				\$ 409,340	409,340			
Page 20 - Resident Care Supplies***								
27.	20	5a2	Prescription Drugs	\$ 212,955	212,955			
28.	20	5d	Ambulance/Limousine	\$ 7,859	7,859			
29.	20	5f	X-rays, etc	\$ 27,658	27,658			
30.	20	5h	Laboratory	\$ 25,019	25,019			
31.			Medical Supplies	\$				
32.	20	5e2	Oxygen (non emergency)	\$ 7,891	7,891			
33.	20	5j	Occupational Therapy	\$ 1,287	1,287			
34.			Other - See Attached Schedule	\$ 14,085	14,085			
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$				
36.			Depreciation on Unallowable Motor Vehicles	\$				
37.			Unallowable Property and Real Estate Taxes	\$				
38.			Rental of Building Space or Rooms	\$				
39.			Other - See Attached Schedule	\$				
Page 27 - Insurance								
40.			Mortgage Insurance	\$				
41.			Property Insurance	\$				
Other - Miscellaneous								
42.			Other - Indirect	\$				
43.			Interest Income on Account Rec.	\$				
44.			Other - Miscellaneous Administrative	\$				
45.			Management Fees Direct	\$				
46.			Management Fees Indirect	\$				
47.			Other - Direct	\$				
Not For Profit Providers Only								
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$				
49. Total Amount of Decrease (Items 1 - 48)				\$ 706,094	706,094			

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

Colonial Health and Rehab Center of Plainfield, LLC
9/30/2021

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Equipment Rental Wound Care	\$ 8,444		
20	5j	Resident Expense	\$ (1,119)		
20	5j	IV Supplies	\$ 5,636		
20	5j	IV Solution	\$ 717		
20	5j	IV Therapy Consult	\$ 407		
Total Other Ancillary Costs			\$ 14,085	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Schedule of Unallowable Building Interest

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended 9/30/2021			Page 30	of 37
		Item	Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 7,613,090	7,613,090				
b. Medicaid Room and Board Contractual Allowance **	\$ (2,443,693)	(2,443,693)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 451,833	451,833				
b. Medicare Room and Board Contractual Allowance **	\$ 1,377,787	1,377,787				
4. a. Private-Pay Residents and Other	\$ 1,798,169	1,798,169				
b. Private-Pay Room and Board Contractual Allowance **	\$ (927,667)	(927,667)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 138,173	138,173				
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$ 103,463	103,463				
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	\$ 1,903,950	1,903,950				
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$ 660,750	660,750				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 215,100	215,100				
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$ 77,550	77,550				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 1,495,400	1,495,400				
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$ 565,600	565,600				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$ (2,390,400)	(2,390,400)				
b. Other (<i>Specify</i>) - Non-Medicare	\$ 11,186	11,186				
III. Total Resident Revenue (Section I. thru Section II.)		\$ 10,650,292	10,650,292			
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$ 366	366				
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$ 69	69				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 695,188	695,188				
V. Total Other Revenue (1 thru 8)		\$ 695,624	695,624			
VI. Total All Revenue (III +V)		\$ 11,345,916	11,345,916			

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30/II6a	Contractual Allow - Med B	\$ (1,537,591)		
30/II6a	Contractual Allow-Med B Seq 2%	\$ (886,732)		
30/II6a	Contractual Allow-Med A Ancill	\$ (11)		
30/II6a	X-Ray -Medicare A	\$ 16,581		
30/II6a	Lab Revenue-Medicare A	\$ 17,354		
Total Other Resident Revenue - Medicare		\$ (2,390,400)	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30/II6b	X-Ray Private Insurance	\$ 2,088		
30/II6b	X-Ray Managed Care	\$ 7,190		
30/II6b	Lab Revenue - Private Ins	\$ 45		
30/II6b	Lab Revenue Managed Care	\$ 1,863		
Total Other Resident Revenue		\$ 11,186	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30-IV5	Interest Income	\$ 69			
Total Interest Income		\$ 69	\$ -	\$ -	

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30/IV8	Miscellaneous Income	\$ 695,188		
Total Other Revenue		\$ 695,188	\$ -	\$ -

G. Balance Sheet

Name of Facility Colonial Health and Rehab Center of Pla	License No. 2387	Report for Year Ended 9/30/2021	Page 31	of 37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$ 1,150,791	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 1,128,089	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$ 71,581	
a. _____				
b. _____				
c. _____				
d. See Schedule		71,581		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$ 211,276	
See Schedule		211,276		
A-9. Total Current Assets (Lines A1 thru 8)			\$ 2,561,737	
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 935,843	Accum. Depreciation 151,597	Net	\$ 784,246
5. Non-Movable Equipment	*Historical Cost 524,763	Accum. Depreciation 256,732	Net	\$ 268,031
6. Movable Equipment	*Historical Cost 778,782	Accum. Depreciation 664,086	Net	\$ 114,696
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-10. Total Fixed Assets (Lines B1 thru 9)			\$ 279,848	

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Colonial Health and Rehab Center of Pl	License No. 2387	Report for Year Ended 9/30/2021	Page 32	of 37
Account		Amount		
Total Brought Forward:			\$	2,841,585
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements	*Historical Cost Accum. Depreciation	Net	\$	
3. Buildings	*Historical Cost Accum. Depreciation	Net	\$	
4. Non-Movable Equipment	*Historical Cost Accum. Depreciation	Net	\$	
5. Movable Equipment	*Historical Cost Accum. Depreciation	Net	\$	
6. Motor Vehicles	*Historical Cost Accum. Depreciation	Net	\$	
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense	*Historical Cost Accum. Depreciation	Net	\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<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. Total Investments and Other Assets (Lines D1 thru 7)			\$	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	2,841,585

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2021	33	37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable			\$	1,168,763
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>)			\$	211,093
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$	
6. Accrued Payroll Taxes Payable			\$	13,521
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>)			\$	124,458
See Schedule			124,458	
A-13. Total Current Liabilities (Lines A1 thru 12)			\$	1,517,835

* 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 9/30/2021	Page 34	of 37
Account				Amount
Total Brought Forward:				1,517,835
Liabilities (cont'd)				
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. Total Long-Term Liabilities (Lines B1 thru 4)				\$
C. Total All Liabilities (Lines A-13 + B-5)				\$ 1,517,835

G. Balance Sheet (cont'd)

Reserves and Net Worth

Name of Facility Colonial Health and Rehab Center of	License No. 2387	Report for Year Ended 9/30/2021	Page 35	of 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				\$ (2,127,908)
4. Treasury Stock				\$
5. Cumulated Earnings				\$ 2,861,581
6. Gain or Loss for Period	10/1/2020	thru	9/30/2021	\$ 590,077
7. Total Net Worth				\$ 1,323,750
C. Total Reserves and Net Worth				\$ 1,323,750
D. Total Liabilities, Reserves, and Net Worth				\$ 2,841,585

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	9/30/2021	36	37
Account				Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2020				\$ 2,976,427
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 11,345,916
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 10,755,839
D. Net Income or Deficit				\$ 590,077
E. Balance				\$ 3,566,504
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 (No., City, State, Zip)		Title	Amount	
2. Other Withdrawings (<i>Specify</i>)				\$
Purpose		Amount		
3. Total Deductions				\$
H. Balance at End of Period				\$ 3,566,504

I. Preparer's/Reviewer's Certification

Name of Facility Colonial Health and Rehab Center of	License No. 2387	Report for Year Ended 9/30/2021	Page 37	of 37
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Check appropriate category

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

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

Signature of Preparer	Title	Date Signed
Printed Name of Preparer		
CJLC, LLC		
Address	Phone Number	
225 Pitkin Street, East Hartford, CT 06108	860-610-9009	
Annual Report Contact	Phone Number	
CJLC, LLC	860-610-9009	
Annual Report Contact Email Address		
annualreports@cjlc.com		