State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2021

Name of Facility (as licensed) Crestfield Rehabilitation Center		
Address (No. & Street, City, State, Zip Code) 565 Vernon Street, Manchester, CT 06042		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021	

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	10140		

For Department Use Only

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Crestfield Rehabilitation Center [facility name], for the cost report period beginning October 1, 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) Phyllis Aronson			Printed Name (Owner) Lawrence Santilli	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

Table of Contents

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1A Rev. 6/95

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Crestfield Rehabilitation Center	Period Covered:		From 10/1/2020	To 9/30/2021
Address of Facility 565 Vernon Street, Manchester, CT 06042				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900		Date 2/12/2021	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$				
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$				
5. All other wages paid	$				
6. ***Total Wages Paid***	$				
7. Total salaries paid	$				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-2 Rev. 10/2005

General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-643-5151	9/30/2021	2	37

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

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

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Type of Ownership (Check appropriate box)

○ Proprietorship ○ LLC ○ Partnership ◉ Profit Corp. ○ Non-Profit Corp. ○ Government ○ Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
Patricia Salisbury		1445

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

Name	License No.:
Not Applicable	

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3 Rev. 10/2005

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
Crestfield Holdings LLC	565 Vernon Street, Manchester, CT 06042	CT

Name of Partners/Members	Business Address	Title	% Owned
Lawrence G. Santilli	135 South Road, Farmington, CT 06032	Manager	0.57

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3A Rev. 10/2005

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	3A	37

If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Not Applicable			
Names of Stockholders Owning at Least 10% of Shares			

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3B Rev. 10/2005

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	3B	37

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

Owner(s) of Facility
Not Applicable

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-4 Rev. 10/2005

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	4	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ◉ No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			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	%**				
Athena Health Care Insurance	135 South Road, Farmington, CT 06032	◉	○	<50%	Self Insured Employee Health & Dental Insu	Pg. 15, ln 1a5	570,714	570,714
Athena Health Care Assoc Inc. 401(K) Plan	135 South Road, Farmington, CT 06032	○	◉		Facility participates in group 401(k) plan			
Procare LTC.	111 Executive Blvd., Farmingdale, NY 11735	◉	○	>50%	Pharmacy	Pg. 20 5a2	372,819	372,819
Athena Health Care	135 South Road, Farmington, CT 06032	○	◉		Various: See attached			
		◉	○					
		○	◉					
		◉	○					
		◉	○					
		○	◉					

* Use additional sheets if necessary.

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-5 Rev. 9/2002

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	5	37

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

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

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

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

Patient care Cons, Laundry, HSKP'g, maintenance/property costs, Admin -allocated on patient days, PT, ST, and OT allocated on % of treatments, Administrative nursing allocated on Direct Nursing hours, Management fees Allocated based on methods above for each category

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

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

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-6 Rev. 9/2002

General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Xerox Financial services	○	⊙	Copier	05/01/21	15 months	1,160	387
Xerox Financial services	○	⊙	Copier	05/01/21	48 months	11,123	4,635
Xerox Financial services	○	⊙	Copier	05/01/21	48 months	10,771	6,282
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
						Total ***	11,304

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
** Attach copies of newly acquired leases.
*** Amount should agree to Page 22, Line 6e.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-7 Rev. 6/95

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	7	37

The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Marcum LLP	555 Long Wharf Drive, New Haven, CT
2 MidCap Financial Services, LLC	7255 Woodmont Avenue, Bethesda, MD 20814
3	
4	

Services Provided by This Firm (*describe fully*)

1	Medicare Cost report: Allowed	$ 2,700
2	LOC Audit/Fees:Disallowed	$ 23,620
3		$
4		$
		Charge for Services Provided $ 26,320

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

⊙ Yes ○ No — Pg 15, Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Goldman, Gruder & Woods, LLC	203-899-8900 / 860-567-0451
2 Murtha Cullina, LLP	860-240-6000
3 Tn of Manchester, Treasurer ST of CT	
4 Pilicy & Ryan PC	860-274-0018
5	

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

1 200 Connecticut Ave, Norwalk, CT 06854
2 185 Asylum Street, Hartford, CT 06103
3 66 Center Street, Manchester, CT
4 365 Main Street, Watertown, CT
5

Services Provided by This Firm (*describe fully*)

1	A/R Collections:Disallowed	$ 2,984
2	annual report filing:Disallowed-$240, Allowed-$80	$ 320
3	Conservatorship: disallowed	$ 900
4	Conservatorship: disallowed	$ 115
5		$
		Charge for Services Provided $ 4,319

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

⊙ Yes ○ No — Pg 15, Line 1e

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 9/2002

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	155	95	60		155	95	60					
B. On last day of THIS report period	155	95	60						155	95	60	
2. Number of Residents												
A. As of midnight of PREVIOUS report period	82	75	7		82	75	7					
B. As of midnight of THIS report period	107	85	22						107	85	22	
3. Total Number of Days Care Provided During Period												
A. Medicare	8,316	6,552	1,764		5,939	4,861	1,078		2,377	1,691	686	
B. Medicaid (Conn.)	22,409	22,409			16,299	16,299			6,110	6,110		
C. Medicaid (other states)												
D. Private Pay	3,063	2,619	444		1,944	1,643	301		1,119	976	143	
E. State SSI for RCH												
F. Other (Specify) Managed Care	245	245			187	187			58	58		
G. Total Care Days During Period (3A thru F)	34,033	31,825	2,208		24,369	22,990	1,379		9,664	8,835	829	
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	34,033	31,825	2,208		24,369	22,990	1,379		9,664	8,835	829	

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	9	37

4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

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

Change in Resident Days	CCNH	RHNS	(Specify)
1st change			
2nd change			
3rd change			
4th change			

6. Number of Residents and Rates on September 30 of Cost Year

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	16	66		10	1	14		
Per Diem Rate								
a. One bed rm.	601.25	291.79		505.00		293.87		
b. Two bed rms.	601.25	291.79		380.00		293.87		
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	5,036	5,036		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,587	1,587		
2. Restorative Treatments				
C. Other	12,284	9,134	3,150	
D. ***Total Physical Therapy Treatments***	18,907	15,757	3,150	
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	1,023	1,023		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	394	394		
2. Restorative Treatments				
C. Other	2,312	1,737	575	
D. ***Total Speech Therapy Treatments***	3,729	3,154	575	
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	3,784	3,784		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,378	1,378		
2. Restorative Treatments				
C. Other	13,333	9,897	3,436	
D. ***Total Occupational Therapy Treatments***	18,495	15,059	3,436	

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	10	37

Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	144,948	2,003	10,056	139		
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	251,830	10,289	17,472	714		
5. Dietary Service						
a. Head Dietitian	72,636	1,985	5,039	138		
b. Food Service Supervisor	61,916	1,708	4,296	119		
c. Dietary Workers	365,678	24,117	25,371	1,673		
6. Housekeeping Service						
a. Head Housekeeper	36,925	1,488	2,562	103		
b. Other Housekeeping Workers	215,636	15,032	14,961	1,043		
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	57,219	1,995	3,970	138		
b. Other Maintenance Workers	35,849	1,953	2,487	136		
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	105,452	6,782	7,316	470		
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	123,688	2,052	23,387	388		
b. RN						
1. Direct Care	520,873	1,482	1,871	75		
2. Administrative**	339,375	19,197	64,168	3,630		
c. LPN						
1. Direct Care	1,076,521	32,083	238,702	8,276		
2. Administrative**						
d. Aides and Attendants	1,408,136	66,703	194,480	11,507		
e. Physical Therapists	259,059	7,244	51,789	1,448		
f. Speech Therapists	77,862	2,106	14,195	384		
g. Occupational Therapists	205,001	5,289	46,775	1,206		
h. Recreation Workers	150,791	6,859	10,462	476		
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	182,381	5,258	12,654	365		
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	5,691,776	215,625	752,013	32,428		

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-11 Rev. 10/2005

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

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	11	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Not Applicable										
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).										
Not Applicable										

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	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* **										
Patricia Salisbury	144,948	10,056		Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	2,142	A2			
Section IV - Assistant Administrators										

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

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	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	17,251	36	1,197	2		
3. Pharmacist	8,074	147	560	10		
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker	38,461	592	2,668	42		
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	60,549	504	4,201	35		
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	397					
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	292	1	53			
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	16,277	218				
2. Administrative***						
b. LPN						
1. Direct Care	7,708	115				
2. Administrative***						
c. Aides	152,949	3,953				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	301,958	5,565	8,679	89		

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

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-14 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Third Eye Health, PO Box 7410158, Chicago, IL 60674	Eye Doctor	○	⊙	
Nurse Network, 405 Park Ave., New York, NY 10022	Nurse Pool	○	⊙	
MAS Medical Staffing, 156 Harvye Road, Londonberry, NH	Nurse Pool	○	⊙	
Procare LTC, 111 Executive Blvd, Farmingdale, NY 11735	Pharmacist	○	⊙	
Towne, 5140 US Highway 9 S, Howell, NJ	Nurse pool	○	⊙	
Southern CT Vascular Center, 6 Research Drive, Suite 105, Shelton, CT 06484	lab services	○	⊙	
NRRON LLC, PO BOX 4470, Springfield, MA	audiology services	○	⊙	
Healthdrive Dental Group, 888 Worcester Street, Wellesley, MA 02482-3744	Dentist	○	⊙	
MASSTEX Imaging LLC, 3 Electronics Ave, Danvers, MA	Speech Therapy	○	⊙	
Norton & Associates, 34 Elm Street, Cohasset, MA 02025	Social service Consulting	○	⊙	
Starling Physicians, PO Box 27728, Salt Lake City Utah	Medical Director/Asst. Medical Director	○	⊙	
Constantine Zariphes MD, 324 Conestoga Way, Glastonbury, CT	Medical Director	○	⊙	
Paramount Healthcare 3 Courthouse Lane, Chelmsford, MA	Nurse Pool	○	⊙	
Healthdrive Audiology, 100 Crossing BLVD, Framingham, MA	audiology services	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		⊙	○	
		○	⊙	
		○	⊙	

* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15 Rev. 9/2018

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	141,788	125,241	16,547	
2. Disability Insurance	$				
3. Unemployment Insurance	$	110,282	97,412	12,870	
4. Social Security (F.I.C.A.)	$	442,236	390,625	51,611	
5. Health Insurance	$	357,866	316,102	41,764	
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	16,729	14,777	1,952	
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	76,032	76,032		
d. Accounting and Auditing	$	26,320	24,612	1,708	
e. Legal (*Services should be fully described on Page 7)*	$	4,319	4,039	280	
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	79,138	74,003	5,135	
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	19,501	18,236	1,265	
2. Cellular Phones	$	911	852	59	
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	552,385	516,547	35,838	
Subtotal	$	1,827,507	1,658,478	169,029	

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,827,507	1,658,478	169,029	
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	5,598	5,235	363	
3. Gifts to Staff and Residents	$	3,604	3,370	234	
4. Employee Travel	$	4,300	4,021	279	
5. Education Expenses Related to Seminars and Conventions	$	3,900	3,647	253	
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	26,015	24,327	1,688	
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	5,817	5,440	377	
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	$	4,151	3,882	269	
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	11,854	11,085	769	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions***	$	500	468	32	
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	139,372	130,330	9,042	
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,032,618	1,850,283	182,335	

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	$ 5,440	$ 377	
Total Other Advertising	$ 5,440	$ 377	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 8,186	$ 568	
AHCA	$ 2,899	$ 201	
Total Dues	$ 11,085	$ 769	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Miscellaneous	$ 468	$ 32	
Total Contributions	$ 468	$ 32	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Charges	$ 43,288	$ 3,003	
Payroll Processing Fees	$ 19,196	$ 1,332	
Employee Physicals	$ 9,147	$ 635	
energy audit	$ 3,522	$ 244	
	$ -		
Data Processing	$ 54,850	$ 3,805	
Licenses	$ 327	$ 23	
Total Other Administrative and General	$ 130,330	$ 9,042	$ -

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

Schedule C-1 - Management Services*

Name of Facility Crestfield Rehabilitation Center	License No. 2344	Report for Year Ended 9/30/2021	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 #
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032		Contract Attached to a Prior Year	See Below
Allocation of the above		Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12
Athena Health Care Assoc., Inc. 135 South Road Farmington, CT 06032		Admin/Gen - Other Exp	Pg 16, Line 12

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-18 Rev. 9/2018

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

Name of Facility	License No.	Report for Year Ended	Page of
Crestfield Rehabilitation Center	2344	9/30/2021	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	270,989	253,408	17,581	
2. Non-Food Supplies	$	12,385	11,581	804	
3. Other (*Specify*)_____ Dishes	$	4,340	4,058	282	
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	287,714	269,047	18,667	

2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F. Resident Meals:	Total no. of meals served per day:*	262	262		

G.	Is cost of employee meals included in 2D?	⦿ Yes	○ No	
H.	Did you receive revenue from employees?	○ Yes	⦿ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	⦿ Yes	○ No	If yes, specify cost.
K.	Is any revenue collected from these people?	○ Yes	⦿ No	If yes, specify amt.
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	○ Yes	⦿ No	If yes, specify cost.
N.	Is any revenue collected from employees?	○ Yes	⦿ No	If yes, specify amt.
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Crestfield Rehabilitation Center	2344	9/30/2021	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $	17,816	16,660	1,156	
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*) Supplies	$	12,744	11,917	827	
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	30,560	28,577	1,983	

3E.	Laundry Questionnaire			
F.	Is cost of employee laundry included in 3D?	○ Yes	⊙ No	If yes, specify cost.
G.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
H.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	
I.	Is Cost of laundry provided to persons other than employees or residents included in 3D?	○ Yes	⊙ No	If yes, specify cost.
J.	Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
K.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3D.

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	41,635	38,934	2,701	
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	41,635	38,934	2,701	
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Procare		$	416,285	416,285		
b. Medicine Cabinet Drugs		$	28,468	26,621	1,847	
c. Medical and Therapeutic Supplies		$	282,537	264,207	18,330	
d. Ambulance/Limousine***		$	(3,946)	(3,946)		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	2,115	1,978	137	
f. X-rays and Related Radiological Procedures***		$	17,122	17,122		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	1,520	1,520		
i. Recreation		$	4,837	4,523	314	
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	77,395	71,386	6,009	
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	826,333	799,696	26,637	

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
	$ -		
Medical Equip Rentals-Medicaid	$ 24,329	$ 1,688	
Physical Therapy Supplies	$ 8,094	$ 1,618	
Oxygen Concentrators	$ 13,737	$ 953	
Cable TV Fees	$ 18,881	$ 1,310	
Medical Equip Rentals-Other	$ 6,345	$ 440	
Total Other Resident Care	$ 71,386	$ 6,009	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 10/2001

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

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
ADP	100 Corporate Drive, Windsor, CT 06095	○	⊙		Payroll Processing	19,196	1,332		16	m13
USA Hauling	PO Box 808, East Windsor, CT 06088	○	⊙		Rubbish Removal	25,706	1,784		22	6f
TRM Landscaping	PO Box 2035, Vernon, CT 06066	○	⊙		Snow Removal and Groundskeeping	40,755	2,827		22	6f
Procare LTC	111 Executive Blvd, Farmingdale, NY 11735	⊙	○	Common Owners: Minority Interest	Pharmacy	348,632	24,188		20	5a2
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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).

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended			Page of
Crestfield Rehabilitation Center	2344	9/30/2021			22 | 37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	138,836	129,830	9,006	
b. Heat	$	49,239	46,045	3,194	
c. Light & Power	$	81,458	76,173	5,285	
d. Water	$	29,890	27,951	1,939	
e. Equipment Lease (*Provide detail on page 6*)	$	11,304	10,571	733	
f. Other (*itemize*)	$	78,292	73,213	5,079	
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	389,019	363,783	25,236	
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$				
d. Movable Equipment	$	23,916	14,658	9,258	
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	23,916	14,658	9,258	
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	3,681	2,256	1,425	
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	3,681	2,256	1,425	
9. Rental payments on leased real property less real estate taxes included in item 10b	$	742,173	454,880	287,293	
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	100,492	61,592	38,900	
c. Personal property taxes	$	17,321	10,616	6,705	
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	887,583	544,002	343,581	

* 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	(Specify)
Groundskeeping	$ 21,494	$ 1,491	
Rubbish Removal	$ 25,706	$ 1,784	
Snow Removal	$ 19,261	$ 1,336	
Supplies	$ 6,752	$ 468	
Total Other Repairs and Maintenance	$ 73,213	$ 5,079	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-23 Rev. 10/2006

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			9	2020	167,423			30,490	S/L	Various	23,145	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2021	12,518				S/L	Various	771	
D-3. Subtotal												23,916
E. ***Total Depreciation***												23,916

Schedule of Land Improvements Acquired during this report period

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

***Ties to Page 23, Line A3**

****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

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

***Ties to Page 23, Line B3**

****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report peri

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

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

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

Schedule of Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
12/31/2020	laptops	$ 1,450	3	$ 242	
1/31/2021	Refidgerator	$ 1,763	10	$ 88	
3/31/2021	patient beds	1758	15	59	
5/31/2021	Café Dining Set	5590	15	186	
7/31/2021	Air Conditioners	1957	5	196	
Total additions for Movable Equipmen		$ 12,518		$ 771	*
Deletions:					
Total deletions for Movable Equipmen		$ -		$ -	**

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
3/31/2021	Roof Top Unit	$ 10,468	10	$ 523	
6/30/2021	Window AC units	$ 3,172	5	$ 317	
6/30/2021	Window AC units	1216	5	122	
Total additions for Leasehold Improvemer		$ 14,856		$ 962	*
Deletions:					
Total deletions for Leasehold Improvemer		$ -		$ -	**

***Ties to Page 24, Line C3**
****Ties to Page 24, Line C2**

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	24	37

Item	Date of Acquisition Month	Date of Acquisition Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1. Bed License									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.		2018							
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period		2020		39,560	3,575	S/L	Var	2,719	
2. Disposals (attach schedule)									
3. Acquired during this report period									
(attach schedule)	9	2021	Various	14,856			Var	962	
C-4. Subtotal									3,681
D. ***Total Amortization***									3,681

* Straight-line method must be used.

** Specify which of the following bases were used:

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-25 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ◉ Yes ○ No

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	12/18/18
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	155
6. Square Footage	
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained	12/18/18			
c. Interest Rate for the Cost Year	6.03%			
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed	5,750,000			
f. Principal balance outstanding as of _____	5,577,500			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-26 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Crestfield Rehabilitation Center	2344	9/30/2021	26 | 37

Item	Total	CCNH	RHNS	(Specify)
12. Interest				
A. Building, Land Improvement & Non-Movable Equipment				
1. First Mortgage $				
Name of Lender / Rate				
Address of Lender				
2. Second Mortgage $				
Name of Lender / Rate				
Address of Lender				
3. Third Mortgage $				
Name of Lender / Rate				
Address of Lender				
4. Fourth Mortgage $				
Name of Lender / Rate				
Address of Lender				
B. CHEFA Loan Information				
1. Original Loan Amount $				
2. Loan Origination Date				
3. Interest Rate %				
4. Term				
5. CHEFA Interest Expense				
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5) $				

(*Carry Subtotals forward to next page*)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-27 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Crestfield Rehabilitation Center	2344	9/30/2021	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*) $	1,150	705	445	
A. Item: Bed license / Rate / Amount				
Lender				
Address of Lender				
B. Item / Rate / Amount				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $	1,150	705	445	
12. D. Other Interest Expense (*Specify*) $	6,608	4,050	2,558	
Vendor Interst=$6,608				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	7,758	4,755	3,003	
14. Insurance				
a. Insurance on Property (buildings only) $	122,978	75,374	47,604	
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)*** $	122,978	75,374	47,604	
15. ***Total All Expenditures (A-13 thru C-14)*** $	11,380,624	9,968,185	1,412,439	

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

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Crestfield Rehabilitation Center	2344	9/30/2021	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	$	251,776	205,001	46,775	
4.			Other - See attached Schedule	$	2,310	2,160	150	
Page 13 - Professional Fees								
5.			Resident Care Physicians **	$	397	397		
6.			Occupational Therapy	$				
7.			Other - See attached Schedule	$				
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.			Bad Debts	$	76,032	76,032		
10.			Accounting	$	23,620	22,203	1,417	
10a.			Legal	$	4,239	3,985	254	
11.			Telephone	$				
12.			Cellular Telephone	$	551	515	36	
13.			Life insurance premiums on the life of Owners, Partners, Operators	$				
14.			Gifts, flowers and coffee shops	$	3,604	3,370	234	
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	$				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	$				
17.			Automobile Expense (e.g. personal use)	$				
18.			Unallowable Advertising *	$	5,817	5,440	377	
19.			Income Tax / Corporate Business Tax	$				
20.			Fund Raising / Contributions	$	500	468	32	
21.			Unallowable Management Fees	$	(169,962)	(159,764)	(10,198)	
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$	46,627	43,602	3,025	
Page 18 - Dietary Expenditures								
24.			Meals to employees, guests and others who are not residents	$	11,470	10,726	744	
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)	$	256,981	214,135	42,846	

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	12m	Community Coordinator: salary & benefits	$ 2,160	$ 150	
Total Other Salaries Adjustment			$ 2,160	$ 150	$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M13	Bank Charges	$ 43,288	$ 3,003	
30	IV8	Medical record income	$ 314	$ 22	
			$ -		
Total Other A&G Adjustments			$ 43,602	$ 3,025	$ -

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	29	37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	256,981	214,135	42,846	
Page 20 - Resident Care Supplies***								
27.			Prescription Drugs	$	416,285	416,285		
28.			Ambulance/Limousine	$	(3,946)	(3,946)		
29.			X-rays, etc	$	17,122	17,122		
30.			Laboratory	$	1,520	1,520		
31.			Medical Supplies	$	21,397	20,009	1,388	
32.			Oxygen (non emergency)	$	2,115	1,978	137	
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	18,675	17,464	1,211	
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$	5,000	3,065	1,935	
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.	$	96	90	6	
44.			Other - Miscellaneous Administrative	$	16,591	15,515	1,076	
45.			Management Fees Direct	$	(46,353)	(43,572)	(2,781)	
46.			Management Fees Indirect	$	(41,203)	(38,731)	(2,472)	
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)***			$	664,280	620,934	43,346	

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

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Medical Equipment Rental	$ 6,345	$ 440	
20	5b	Ebox	$ 11,119	$ 771	
Total Other Ancillary Costs			$ 17,464	$ 1,211	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7f	Movable Equip Depr Carryforward AJE	$ 3,065	$ 1,935	
Total Excess Movable Equipment Depreciation			$ 3,065	$ 1,935	$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

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

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Radio & Television	$ 15,515	$ 1,076	
Total Other Adjustments			$ 15,515	$ 1,076	$ -

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-30 Rev.10/2005

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Crestfield Rehabilitation Center	2344	9/30/2021	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	9,016,386	9,016,386		
b. Medicaid Room and Board Contractual Allowance **	$	(2,974,043)	(2,974,043)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	2,044,833	1,920,251	124,582	
b. Medicare Room and Board Contractual Allowance **	$	950,838	949,656	1,182	
4. a. Private-Pay Residents and Other	$	2,697,026	2,017,539	679,487	
b. Private-Pay Room and Board Contractual Allowance **	$	(152,329)	(158,177)	5,848	
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	187,161	187,161		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(187,161)	(187,161)		
c. Prescription Drugs - Non-Medicare	$	226,896	226,896		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(226,896)	(226,896)		
2. a. Medical Supplies - Medicare	$	(5,497)	(5,897)	400	
b. Medical Supplies - Medicare Contractual Allowance **	$	5,497	5,897	(400)	
c. Medical Supplies - Non-Medicare	$	7,217		7,217	
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(7,217)		(7,217)	
3. a. Physical Therapy - Medicare	$	440,214	396,736	43,478	
b. Physical Therapy - Medicare Contractual Allowance **	$	(315,180)	(292,533)	(22,647)	
c. Physical Therapy - Non-Medicare	$	569,950	399,750	170,200	
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(399,750)	(279,825)	(119,925)	
4. a. Speech Therapy - Medicare	$	181,465	166,700	14,765	
b. Speech Therapy - Medicare Contractual Allowance **	$	(135,586)	(127,895)	(7,691)	
c. Speech Therapy - Non-Medicare	$	220,490	159,660	60,830	
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(220,490)	(159,660)	(60,830)	
5. a. Occupational Therapy - Medicare	$	383,368	347,599	35,769	
b. Occupational Therapy - Medicare Contractual Allowance **	$	(291,121)	(272,490)	(18,631)	
c. Occupational Therapy - Non-Medicare	$	601,215	415,325	185,890	
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(601,215)	(415,325)	(185,890)	
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	1,061,538	1,061,538		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	13,077,609	12,171,192	906,417	
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	96	90	6	
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	1,419,945	1,327,822	92,123	
V. Total Other Revenue (1 thru 8)	$	1,420,041	1,327,912	92,129	
VI. Total All Revenue (III +V)	$	14,497,650	13,499,104	998,546	

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	HHS Funds	$ 166,927		
	HHS Funds	$ 894,611		
	0	$ -		
Total Other Resident Revenue		$ 1,061,538	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
pg 31, L A2	Interest on A/R		$ 90	$ 6	
Total Interest Income			$ 90	$ 6	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
N/A	Bad debt recoveries	$ 18,346	$ 1,273	
	Medical records revenues	$ 305	$ 21	
	PPP Loan forgiveness	$ 1,309,171	$ 90,829	
Total Other Revenue		$ 1,327,822	$ 92,123	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-31 Rev. 6/95

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 36,570
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 2,387,210
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ (19,694)
4 Inventories				$ 14,700
5. Prepaid Expenses				$ 155,219
a. Prepaid Insurance		144,870		
b. Prepaid Health Insurance		6,236		
c. Other Prepaid Expenses		534		
d. See Schedule		3,579		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$ (17,869)
8. Other Current Assets (*itemize*)				$ 10,211
A/R related party		10,211		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,566,347
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	54,416		$ 47,160
	Accum. Depreciation	7,256	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	142,441		$ 88,035
	Accum. Depreciation	54,406	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 37,500
Excluded Movable Equipment		37,500		
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 172,695

* 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	
		Prepaid expense	$ 3,579
Total Prepaid Expenses			$ 3,579

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

Page Ref	Line Ref	Description	
Total Other Current Assets (Itemize)			$ -

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

Page Ref	Line Ref	Description	
Total Other Other Fixed Assets (Itemize)			$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Deposit - Utilities	$ 4,855
		Project Development	$ 635,667
		0	$ -
Total Other Assets			$ 640,522

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ -

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

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-32 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	32	37

Account				Amount
			Total Brought Forward:	$ 2,739,042
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$ 1,890,057
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
Deferred Finance fees				
7. Other Assets (*itemize*)				$ 640,522
See Attachecd				
See Schedule		640,522		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 2,530,579
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 5,269,621

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-33 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 2,566,911
2. Notes Payable (*itemize*)				$ (2,524,408)
Due from Related Party			(651,717)	
Line of Credit			(1,872,691)	
See Schedule				
3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 313,889
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 343,450
7. Medicare Final Settlement Payable				$
8. Medicare Current Financing Payable				$
9. Mortgage Payable (*Current Portion*)				$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
11. Accrued Income Taxes*				$
12. Other Current Liabilities (*itemize*)				$ 1,219,439
		Due to Medicaid-Provide	977,640	
Acc'd Int-Private Pay Security Depo		Accd Health Insurance	6,947	
Acc'd Operating Expenses	134,157	Due to Medicaid	100,492	
Acc'd Expense - CT Sales Tax	203	See Schedule		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 1,919,281

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

(Carry Total forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-34 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	34	37

Account	Amount
Total Brought Forward:	1,919,281
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$ 5,992

Name of Lender	Purpose	Amount	Date Due
	Capital Lease		

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

Name and Address of Lender	Amount	Loan Date
Due to Related Party	1,305,892	None

4. Other Long-Term Liabilities (*itemize*)	$
Note Payable	
See Schedule	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 1,311,884
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 3,231,165

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-35 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	35	37

Account					Amount
A. **Reserves**					
1. Reserve for value of leased land					$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized					$
3. Reserve for depreciation value of leased personal property (*Equity)*					$
4. Reserve for leasehold real properties on which fair rental value is based					$
5. Reserve for funds set aside as donor restricted					$
6. Total Reserves					$
B. **Net Worth**					
1. Owner's Capital					$
2. Capital Stock					$
3. Paid-in Surplus					$
4. Treasury Stock					$
5. Cumulated Earnings					$ (953,988)
6. Gain or Loss for Period	10/1/2020	thru	9/30/2021		$ 2,992,444
7. Total Net Worth					$ 2,038,456
C. ***Total Reserves and Net Worth***					$ 2,038,456
D. ***Total Liabilities, Reserves, and Net Worth***					$ 5,269,621

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-36 Rev. 6/95

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2020			$ (953,559)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 14,373,068
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 11,380,624
D.	Net Income or Deficit			$ 2,992,444
E.	Balance			$ 2,038,885
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Prior year expense adjmt-2020 - Recreation exp			(228)
	Prior year expense adjmt-2020-fixed asset adjmt			(201)
	2. Other (*itemize*)			
F-3.	Total Additions			$ (429)
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period*** 09/30/21			$ 2,038,456

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-37 Rev. 9/2002

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Crestfield Rehabilitation Center	2344	9/30/2021	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer

Athena Health Care Associates, Inc

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

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

Contact Email Address

lrinadli@athenahealthcare.com