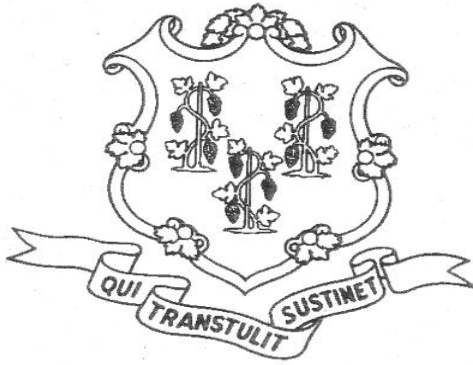


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2017

Name of Facility (as licensed) Colonial Health & Rehab Center of Plainfield, LLC	
Address (No. & Street, City, State, Zip Code) 16 Windsor Ave., Plainfield, CT 06374	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

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 & Rehab Center of Plainfield, LLC	License No. 2387	Report for Year Ended 9/30/2017	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 & Rehab Center of Plainfield, LLC [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, 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)		
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 & Rehab Center of Plainfield, LLC		Period Covered:	From 10/1/2016	To 9/30/2017
Address of Facility 16 Windsor Ave., Plainfield, CT 06374				
Report Prepared By CJLC LLC		Phone Number 860-610-9009	Date 2/2/2018	
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 860-564-4081		Report for Year Ended 9/30/2017		Page 2	of 37
Name of Facility (as shown on license) Colonial Health & 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 Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing 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.:	001775	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		

General Information and Questionnaire
Related Parties*

Name of Facility Colonial Health & Rehab Center of Plainfield, LLC	License No. 2387	Report for Year Ended 9/30/2017	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
		<input checked="" type="radio"/>	<input type="radio"/>					
See attachment to pages 11 & 12 for detailed information for related parties		<input type="radio"/>	<input checked="" type="radio"/>					
Rosemarie Rodowicz d/b/a Keystone Ergonomics	13730 Whispering Lakes Lane, Palm Beach Gardens, FL 33418	<input checked="" type="radio"/>	<input type="radio"/>		Medical management: WC, Ergonomic Inspections, OSHA		7,377	7,377
Deborah Darigan d/b/a Barr-Nunn, LLC	74 Lennys Lane, Hampton, CT 06247	<input checked="" type="radio"/>	<input type="radio"/>		Medical Record Management		3,780	3,780
Colonial Health & Rehab Management, LLC	13730 Whispering Lakes Lane, Palm Beach Gardens, FL 33418	<input type="radio"/>	<input checked="" type="radio"/>		Management Services	16/m12	187,013	187,013
		<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 & Rehab Center of Plainfield, CT	License No. 2387	Report for Year Ended 9/30/2017	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.

Name of Facility			License No.	Report for Year Ended			Page	of
Colonial Health & Rehab Center of Plainfield, LLC			2387	9/30/2017			6	37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease		Amount Claimed
	Yes	No						
Ricoh USA, Inc. 70 Valley Stream Parkway, Malvern, PA 19355	<input type="radio"/>	<input checked="" type="radio"/>	Copier	04/18/13	1 year	3,120		3,120
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?								
<input type="radio"/> Yes <input type="radio"/> No								
Total ***								3,120

* 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 & Rehab Center of	License No. 2387	Report for Year Ended 9/30/2017	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 Street, East Hartford, CT 06108
--	---

Services Provided by This Firm (*describe fully*)

1 Medicaid and Medicare Cost Report, Audited Financial Statements, Tax Services	\$ 17,321
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 17,321

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 1 2 3 4 5	Telephone Number
---	------------------

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1 See attached schedule	\$ 107,305
2	\$
3	\$
4	\$
5	\$
	Charge for Services Provided
	\$ 107,305

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

- Yes No Pg 15/1e

Schedule of Resident Statistics

Name of Facility Colonial Health & Rehab Center of Plainfield, LLC			License No. 2387		Report for Year Ended 9/30/2017				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												
A. On last day of PREVIOUS report period	90	90			90	90			90	90		
B. On last day of THIS report period	90	90			90	90			90	90		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	90	90			90	90			90	90		
B. As of midnight of THIS report period	90	90			90	90			90	90		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,900	4,900			3,648	3,648			1,252	1,252		
B. Medicaid (Conn.)	22,035	22,035			16,588	16,588			5,447	5,447		
C. Medicaid (other states)												
D. Private Pay	3,482	3,482			2,625	2,625			857	857		
E. State SSI for RCH												
F. Other (Specify) Managed Care, Insurance, Hosp	668	668			368	368			300	300		
G. Total Care Days During Period (3A thru F)	31,085	31,085			23,229	23,229			7,856	7,856		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	97	97			65	65			32	32		
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	31,182	31,182			23,294	23,294			7,888	7,888		

Schedule of Resident Statistics (Cont'd)

Name of Facility Colonial Health & Rehab Center of Plainfield			License No. 2387			Report for Year Ended 9/30/2017			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	RHNS	CCNH	RHNS	(Specify)	CCNH	RHNS	(Specify)	R.C.H.	ICF-IID			
No. of Residents	11		73			5							
Per Diem Rate													
a. One bed rm.	575.49		236.76			390.00							
b. Two bed rms.						370.00							
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									3,999	3,999			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									78	78			
D. Total Physical Therapy Treatments									4,077	4,077			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									1,363	1,363			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									24	24			
D. Total Speech Therapy Treatments									1,387	1,387			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									2,518	2,518			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									75	75			
D. Total Occupational Therapy Treatments									2,593	2,593			

Report of Expenditures - Salaries & Wages

Name of Facility Colonial Health & Rehab Center of Plainfield, LLC	License No. 2387	Report for Year Ended 9/30/2017	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)	115,134	1,984				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	206,743	10,822				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	278,778	17,577				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	166,410	8,734				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	78,558	2,941				
b. Other Maintenance Workers						
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	32,057	4,745				
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	107,609	2,159				
b. RN						
1. Direct Care	449,252	10,271				
2. Administrative**	228,549	4,450				
c. LPN						
1. Direct Care	761,494	25,658				
2. Administrative**						
d. Aides and Attendants	1,395,647	75,906				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	105,243	4,074				
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	43,268	1,541				
n. Marketing						
o. Other (Specify) See Attached Schedule	66,860					
<i>A-13. Total Salary Expenditures</i>	4,035,602	170,862				

* 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)

Position	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Admission Director Wages	\$ 55,250					
Admission Staff Wages OT	\$ 1,054					
PIL of Benefits Admissions	\$ 2,245					
Vacation Admissions	\$ 4,202					
Sick Admissions	\$ 1,260					
Personal Admissions	\$ 420					
Holiday Admissions	\$ 2,303					
Hol. Worked Admissions	\$ 125					
Total	\$ 66,860	-	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

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

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

Name of Facility				License No.	Report for Year Ended			Page	of	
Colonial Health & Rehab Center of Plainfield, LLC				2387	9/30/2017			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										
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).										
See Attachment.										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
Colonial Health & Rehab Center of Plainfield, LLC				2387	9/30/2017			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 (10/1/16 to 9/30/17)	115,134				Administrator	1,984	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		
Colonial Health & Rehab Center of Plainfield, LLC	2387	9/30/2017	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	9,360	144				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	309,658	5,480				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	32,575	234				
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) Dental Consultant	5,201	20				
9. Speech Therapist						
a. Resident Care	67,856	1,074				
b. Other						
10. Occupational Therapist						
a. Resident Care	277,841	6,179				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	6,234	148				
2. Administrative***						
b. LPN						
1. Direct Care	21,126	376				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	740,057	13,654				

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

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

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Colonial Health & Rehab Center of Plainfield, LLC		2387	9/30/2017		14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
HealthPro Therapy Service, LLC 10600 York Road, Suite 105, Cockeysville, MD	PT, ST, OT	<input type="radio"/>	<input checked="" type="radio"/>			
Healthdrive 88 Worcester St, Wellesley, MA 02482	Dental Consultant	<input type="radio"/>	<input checked="" type="radio"/>			
Pro Health Pysicians P.O. Box 150483, Hartford, CT 06115	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
Pro Health Pysicians P.O. Box 150483, Hartford, CT 06115	Physician Fees	<input type="radio"/>	<input checked="" type="radio"/>			
Superior Scheduling & Consulting 1326 SW Sultan Drive, Port St. Lucie, FL 34953	Facility Scheduling	<input type="radio"/>	<input checked="" type="radio"/>			
Partners Pharmacy of CT PO Box 9689, Uniondale, NY 11555	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>			
Mobile X USA 109 Rhode Island Rd., Lakeville, MA 02347	Diagnostics	<input type="radio"/>	<input checked="" type="radio"/>			
US Laboratory 2 Jonathan Dr., Brockton, MA 02301	Phlebotomist	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Colonial Health & Rehab Center of Plainfield, LI	2387	9/30/2017		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 281,029	281,029			
2. Disability Insurance	\$ 16,397	16,397			
3. Unemployment Insurance	\$ 101,785	101,785			
4. Social Security (F.I.C.A.)	\$ 309,037	309,037			
5. Health Insurance	\$ 656,120	656,120			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 228,310	228,310			
8. Uniform Allowance	\$ 8,346	8,346			
9. Other (<i>Specify</i>) See Attached Schedule	\$ 37,107	37,107			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 51,750	51,750			
d. Accounting and Auditing	\$ 17,321	17,321			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 107,305	107,305			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$ 11,996	11,996			
g. Office Supplies	\$ 28,282	28,282			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 8,636	8,636			
2. Cellular Phones	\$				
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 139	139			
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (<i>Specify</i>) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 548,054	548,054			
Subtotal	\$ 2,411,614	2,411,614			

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended		Page	of
Colonial Health & Rehab Center of Plainfield, LLC	2387	9/30/2017		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:					
	2,411,614	2,411,614			
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 8,277	8,277			
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 3,067	3,067			
5. Education Expenses Related to Seminars and Conventions	\$ 2,608	2,608			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>)	\$ 4,851	4,851			
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 5,606	5,606			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$ 1,591	1,591			
3. Advertising Other (<i>Specify</i>)***	\$				
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	\$ 4,719	4,719			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>)	\$				
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 9,757	9,757			
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>)	\$ 28,787	28,787			
12. Administrative Management Services**	\$ 187,013	187,013			
13. Other (<i>Specify</i>)	\$ 104,368	104,368			
See Attached Schedule					
C-14 Total Administrative & General Expenditures	\$ 2,772,257	2,772,257			

* 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)
A & G Meal & Entertainment	\$ 4,851		
Total Other Travel and Entertainment	\$ 4,851	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Total Other Advertising	\$ -	\$ -	\$ -

Schedule of Dues

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

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
A & G Late Fees	\$ 253		
A & G Background checks	\$ 3,730		
License & Permit fees	\$ 980		
Bank fees	\$ 9,437		
Community awarness	\$ 14,842		
Software Maintenance	\$ 75,125		
Total Other Administrative and General	\$ 104,368	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Colonial Health & Rehab Center of Plainf	2387	9/30/2017	17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Colonial Health & Rehab Management, LLC	187,013	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 & Rehab Center of Plainfield, LLC		License No. 2387	Report for Year Ended 9/30/2017	Page 18	of 37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 196,076	196,076		
2.	Non-Food Supplies	\$ 18,389	18,389		
3.	Other (Specify) _____	\$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$ 129,560	129,560		
c. Management Services**		\$			
d. Other (Specify) _____		\$			
2E. Total Dietary Expenditures (2a + b + c + d)		\$ 344,025	344,025		
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*		262	262		
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No					
I. Did you receive revenue from employees? <input checked="" type="radio"/> Yes <input type="radio"/> No If yes, specify amt.					
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
O. Is any revenue collected from employees? <input checked="" type="radio"/> Yes <input type="radio"/> No If yes, specify amt. \$472					
P. 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.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Name of Facility		License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plainfield, LLC		2387	9/30/2017	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. \$	12,310	12,310	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	29,683	29,683	
c. Management Services**		\$			
d. Other (Specify) Laundry Supplies		\$	2,922	2,922	
3E. Total Laundry Expenditures (3a + b + c + d)		\$	44,914	44,914	
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
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 laundry provided to persons other than employees or residents included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K. Did you receive revenue from these people?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
L. Where is the revenue received reported in the Cost Report?		(Page/Line Item)			

* 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 3E.

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of	
Colonial Health & Rehab Center of Plainfield, I	2387	9/30/2017	20	37	
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care					
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	24,190	24,190		
b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
	Amt. \$	39,076	39,076		
c. Management Services*	\$				
d. Other (<i>Specify</i>)	\$				
4E. Total Housekeeping Expenditures (4a + b + c + d)	\$	63,265	63,265		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	221,081	221,081		
b. Medicine Cabinet Drugs	\$	13,481	13,481		
c. Medical and Therapeutic Supplies	\$	37,624	37,624		
d. Ambulance/Limousine***	\$	14,211	14,211		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	12,290	12,290		
f. X-rays and Related Radiological Procedures***	\$	17,624	17,624		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	19,308	19,308		
i. Recreation	\$				
j. Other (Specify)**** See Attached Schedule	\$	173,750	173,750		
5K. Total Resident Care Expenditures (5a - 5j)	\$	509,369	509,369		

* 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.

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

Name of Facility Colonial Health & Rehab Center of Plainfield, LLC			License No. 2387		Report for Year Ended 9/30/2017				Page of 21 37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Healthcare Services Group, Inc.	3220 Tillman Drive, Bansalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		Dietary Services	129,560			18	2b
Healthcare Services Group, Inc.	3220 Tillman Drive, Bansalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		Laundry Services	29,683			19	3b
Healthcare Services Group, Inc.	3220 Tillman Drive, Bansalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		Housekeeping Services	39,076			20	4b
Point Click Care	6975 Creditview Road, Unit 4, Mississauga,	<input type="radio"/>	<input checked="" type="radio"/>		Software Provider	28,787			16	m11
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							

* List all contracted services over \$10,000. Use additional sheets if necessary.
 ** Refer to Page 4 for definition of related.
 *** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended			Page	of
Colonial Health & Rehab Center of Plainfield,	2387	9/30/2017			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 67,613	67,613				
b. Heat	\$ 44,838	44,838				
c. Light & Power	\$ 99,050	99,050				
d. Water	\$ 19,562	19,562				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 3,120	3,120				
f. Other (<i>itemize</i>)	\$ 42,139	42,139				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 276,321	276,321				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$ 38,367	38,367				
d. Movable Equipment	\$ 104,041	104,041				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 142,409	142,409				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$ 21,413	21,413				
c. Leasehold Improvements	\$ 22,498	22,498				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 43,911	43,911				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 387,286	387,286				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 92,308	92,308				
c. Personal property taxes	\$ 13,038	13,038				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 678,952	678,952				

* 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)
Plant Garbage	\$ 27,571		
Equipment rental	\$ 14,567		
Total Other Repairs and Maintenance	\$ 42,139	\$ -	\$ -

4/11/2017	Office Depot - Glass Bulletin Board Lobby	\$ 585	7	\$ 42
5/24/2017	P&J Sprinkler - Install 3 dry DR Soffit	\$ 4,374	7	\$ 260
6/19/2017	Lowe's - 2 Air Conditioners Rehab (Replace)	\$ 849	7	\$ 40
6/20/2017	P&J Sprinkler - Back Flow repairs 4" valve	\$ 1,011	7	\$ 48
6/30/2017	Scherber - 4 Hours 6/27 Install 2 AC units in wall Therapy	\$ 200	7	\$ 10
6/30/2017	Scherber - 6 Hours 6/26 Install 2 AC units in wall Therapy	\$ 300	7	\$ 14
7/5/2017	C&C Electrical Therapy wiring for new AC units	\$ 621	7	\$ 22
9/18/2017	Stanley Security Solutions - 3 Wander guard Door Sensors	\$ 4,088	7	\$ 49
Total additions for Non-Movable Equipment		\$ 89,180		\$ 8,264 *
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
12/13/2016	Direct Supply - Order#22003363/PO#12716	\$ 2,026	5	\$ 304
12/23/2016	Direct Supply - Order#21997259- Mattress December 2016	\$ 759	5	\$ 114
12/29/2016	Direct Supply - Trapeze- Order#21824678	\$ 657	5	\$ 98
1/5/2017	Seating Expert - 8 New Chairs Dining Room	\$ 1,043	5	\$ 156
1/27/2017	Direct Supply - Order#22122464- Oxygen Concentrators	\$ 5,125	5	\$ 769
1/13/2017	CareWorx, Inc. - Order#341- Kiosk Mounting Brackets	\$ 659	5	\$ 99
3/16/2017	Bemes, Inc. - Bipap S/T Respiratory Equip	\$ 1,328	5	\$ 155
3/23/2017	Direct Supply - Order#22282361/PO#32117	\$ 1,580	5	\$ 184
4/5/2017	Direct Supply - Bariatric bed kit	\$ 497	5	\$ 50
4/6/2017	Direct Supply - Mattress	\$ 255	5	\$ 26
5/8/2017	Direct Supply - Order#22402261/PO#5317	\$ 206	5	\$ 17
5/15/2017	Direct Supply - 2 Air Mattress	\$ 3,697	5	\$ 308
6/6/2017	Connecticut Communications - Telephone System	\$ 6,344	5	\$ 423
6/8/2017	Direct Supply - Kitchen Steamer	\$ 5,690	5	\$ 379
7/7/2017	Direct Supply - 2 Oxygen Sensors	\$ 904	5	\$ 45
7/19/2017	Connecticut Communications - Phone Installation	\$ 688	5	\$ 34
7/11/2017	Medline Industries, Inc. - Bladder Scanner	\$ 7,391	5	\$ 370
8/11/2017	Robert W Wagner - 3 bay kitchen compressor	\$ 957	5	\$ 48
9/4/2017	Direct Supply - Easy Care 7 Bed (1)	\$ 2,091	5	\$ 35
9/21/2017	Walmart - 4 Resident Romm 32" TV's	\$ 574	5	\$ 10
Total additions for Movable Equipment		\$ 42,471		\$ 3,624 *
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:				
11/21/2016	Northeast Flooring & Kitchens, LLC - Tile Install	\$ 585	15	\$ 29
6/12/2017	HD Supply Facilities Maintenance LTD - Door Handles	\$ 3,391	15	\$ 75
6/30/2017	Scherber - 8 Hours 6/20 Door Knob Replacements	\$ 400	15	\$ 9
6/30/2017	Scherber - 11 Hours 6/19 Door Knob Replacements	\$ 550	15	\$ 12
6/23/2017	HD Supply - Door Knob replacements	\$ 1,344	15	\$ 30
6/27/2017	HD Supply - Door Knob replacements	\$ 663	15	\$ 15
8/28/2017	Killingly Glass & Aluminum - Window (21) Replacements	\$ 8,973	15	\$ 100
Total additions for Leasehold Improvement		\$ 15,907		\$ 270 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility

Amortization Schedule*

Name of Facility			License No.		Report for Year Ended			Page	of
Colonial Health & Rehab Center of Plainfield, LLC			2387		9/30/2017			24	37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period	Var	Var	Var	779,287	43,559	SL	Var	22,228	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				15,907				270	
C-4. Subtotal									22,498
D. Total Amortization									22,498

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility Colonial Health & Rehab Center of Pl	License No. 2387	Report for Year Ended 9/30/2017	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input 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	12/29/2012			
4. Date of Initial Licensure	7/13/1983			
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)	Fixed			
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year	3.35%			
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of 9/30/20__				
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			Page	of
Colonial Health & Rehab Center of P		2387	9/30/2017			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)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Colonial Health & Rehab Center of		2387		9/30/2017		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) Interest Expense				\$ 94,681	94,681		
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$ 94,681	94,681		
14. Insurance							
a. Insurance on Property (buildings only)				\$ 78,801	78,801		
b. Insurance on Automobiles				\$ 443	443		
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)				\$ 79,244	79,244		
15. Total All Expenditures (A-13 thru C-14)				\$ 9,638,687	9,638,687		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Colonial Health & Rehab Center of Plainfield, LLC			2387	9/30/2017	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	\$ 277,841	277,841		
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 51,750	51,750		
10.	15	1e	Accounting & Legal	\$ 13,745	13,745		
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	Unallowable Advertising *	\$ 1,591	1,591		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.	16	m12	Unallowable Management Fees	\$ 187,013	187,013		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 19,946	19,946		
Page 18 - Dietary Expenditures							
24.	30	IV1	Meals to employees, guests and others who are not residents	\$ 472	472		
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)				\$ 564,353	564,353		

* 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	L7	A & G Meal & Entertainment	\$ 4,851		
16	m13	A & G Late Fees	\$ 253		
16	m13	Community awarness	\$ 14,842		
Total Other A&G Adjustments			\$ 19,946	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Colonial Health & Rehab Center of Plainfield, LLC			2387	9/30/2017	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 564,353	564,353		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 221,081	221,081		
28.	20	5d	Ambulance/Limousine	\$ 14,211	14,211		
29.	20	5f	X-rays, etc	\$ 17,624	17,624		
30.			Laboratory	\$ 19,308	19,308		
31.			Medical Supplies	\$			
32.	20	5e2	Oxygen (non emergency)	\$ 12,290	12,290		
33.	20	5j	Occupational Therapy	\$ 1,917	1,917		
34.			Other - See Attached Schedule	\$ 84,899	84,899		
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.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$			
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51.	Total Amount of Decrease (Items 1 - 50)			\$ 935,683	935,683		

*** 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 & Rehab Center of Plainfield, LLC
9/30/2017

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	IV solution	\$ 37,357		
20	5j	Incontinent Care Diapers	\$ 44,877		
20	5j	Wound Care Medicare A	\$ 641		
20	5j	Resident expense	\$ 2,024		
Total Other Ancillary Costs			\$ 84,899	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Colonial Health & Rehab Center of Plain	2387	9/30/2017		30	37
Item	Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 7,805,383	7,805,383			
b. Medicaid Room and Board Contractual Allowance **	\$ (2,655,386)	(2,655,386)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 2,819,887	2,819,887			
b. Medicare Room and Board Contractual Allowance **	\$ (48,308)	(48,308)			
4. a. Private-Pay Residents and Other	\$ 1,689,188	1,689,188			
b. Private-Pay Room and Board Contractual Allowance **	\$ (162,225)	(162,225)			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 214,178	214,178			
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$ 52,790	52,790			
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	\$ 769,975	769,975			
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$ 65,565	65,565			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$ 145,300	145,300			
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$ 3,600	3,600			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$ 787,400	787,400			
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$ 73,250	73,250			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other (<i>Specify</i>) - Medicare	\$ (1,667,596)	(1,667,596)			
b. Other (<i>Specify</i>) - Non-Medicare	\$ 548	548			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 9,893,550	9,893,550			
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$ 472	472			
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$ 74	74			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$				
V. Total Other Revenue (1 thru 8)	\$ 546	546			
VI. Total All Revenue (III +V)	\$ 9,894,096	9,894,096			

* 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	X-Ray -Medicare A	\$ 9,995		
30/II6a	Lab Revenue-Medicare A	\$ 13,803		
30/II6a	Contractual Allow-Med A Ancill	\$ (1,555,856)		
30/II6a	Contractual Allow - Med B	\$ (130,926)		
30/II6a	Contractual Allow-Med B Seq 2%	\$ (4,612)		
Total Other Resident Revenue - Medicare		\$ (1,667,596)	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30/II6b	X-ray Managed Care	\$ 452		
30/II6b	Lab Revenue Managed Care	\$ 96		
Total Other Resident Revenue		\$ 548	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30/IV5	Interest Income		\$ 74		
Total Interest Income			\$ 74	\$ -	\$ -

Schedule of Other Revenue

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

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Pla	2387	9/30/2017	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	237,234
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	832,096
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	110,963
a. Prepaid Insurance	44,620			
b. Prepaid Expenses	36,585			
c. Prepaid Taxes	29,758			
d.				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	299,432
HUD Tax	21,820			
HUD Insurance	69,462			
HUD Replacement Reserves	208,150			
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,479,725
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
4. Leasehold Improvements	*Historical Cost <u>795,194</u>		\$	729,138
	Accum. Depreciation <u>66,056</u>	Net		
5. Non-Movable Equipment	*Historical Cost <u>290,988</u>		\$	192,818
	Accum. Depreciation <u>98,170</u>	Net		
6. Movable Equipment	*Historical Cost <u>584,243</u>		\$	252,920
	Accum. Depreciation <u>331,323</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	21,413
Capitalized Finance Costs	21,413			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	1,196,290

* 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 & Rehab Center of Pla	License No. 2387	Report for Year Ended 9/30/2017	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	2,676,015
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>)			\$	50,000
	Security Deposits - Long Term	50,000		

D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	50,000
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	2,726,015

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

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Plainfield,		2387	9/30/2017	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	1,033,405
2. Notes Payable (<i>itemize</i>)				\$	

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>)				\$	234,476
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	43,543
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>)				\$	752,722
401-K / Pension / Health		2,827	Line of Credit -AR (SCM	713,253	
Withholding Aflac		922	Capital Lease Payable	27,723	
Garnishments		340	Home Depot Credit	466	
Union Withheld		1,972	American Express	5,218	
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	2,064,146

* 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 & Rehab Center of Plainfield	License No. 2387	Report for Year Ended 9/30/2017	Page 34	of 37
Account				Amount
Total Brought Forward:				2,064,146
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>)				\$
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$
C. Total All Liabilities (Lines A-13 + B-5)				\$ 2,064,146

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

Name of Facility	License No.	Report for Year Ended	Page	of
Colonial Health & Rehab Center of Pl	2387	9/30/2017	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	5,016
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	401,444
6. Gain or Loss for Period			\$	255,409
	10/1/2016	thru	9/30/2017	
7. Total Net Worth			\$	661,869
C. Total Reserves and Net Worth			\$	661,869
D. Total Liabilities, Reserves, and Net Worth			\$	2,726,015

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of	
Colonial Health & Rehab Center of Plain	2387	9/30/2017	36	37	
Account			Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2016			\$	481,616	
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	9,894,096	
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	9,638,687	
D. Net Income or Deficit			\$	255,409	
E. Balance			\$	737,025	
F. Additions					
1. Additional Capital Contributed (<i>itemize</i>)					
2. Other (<i>itemize</i>)					
F-3. Total Additions			\$		
G. Deductions					
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$		
Name and Address (<i>No., City, State, Zip</i>)		Title	Amount		
2. Other Withdrawings (<i>Specify</i>)			\$		
Purpose		Amount			
3. Total Deductions			\$		
H. Balance at End of Period			\$	737,025	
09/30/17					

I. Preparer's/Reviewer's Certification

Name of Facility Colonial Health & Rehab Center of	License No. 2387	Report for Year Ended 9/30/2017	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
CJLC LLC				
Address			Phone Number	
225 Pitkin Street, East Hartford, CT 06108			860-610-9009	