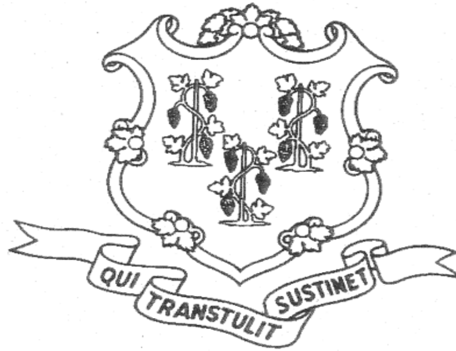
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2021

Name of Facility (as licensed)	
Montowese Health & Rehabilitation Center	
Address (No. & Street, City, State, Zip Code) 163 Quinnipiac Avenue, North Haven, CT 06473	
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
	2442			07-5017

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	000010157		

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
Montowese Health & Rehabilitation Center	2442	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 Montowese Health & 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) Patrick McDonnell			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

General Information - Administrator's/Owner's Certification		1
General Information and Questionnaire - Data Required for Real Wage Adjustment		1A
General Information and Questionnaire - Type of Facility - Organization Structure		2
General Information and Questionnaire - Partners/Members		3
General Information and Questionnaire - Corporate Owners		3A
General Information and Questionnaire - Individual Proprietorship		3B
General Information and Questionnaire - Related Parties		4
General Information and Questionnaire - Basis for Allocation of Costs		5
General Information and Questionnaire - Leases		6
General Information and Questionnaire - Accounting Basis		7
Schedule of Resident Statistics		8
Schedule of Resident Statistics (Cont'd)		9
A.	Report of Expenditures - Salaries & Wages	10
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B.	Report of Expenditures - Professional Fees	13
	Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C.	Expenditures Other than Salaries - Administrative and General	15
C.	Expenditures Other than Salaries (Cont'd) - Administrative and General	16
	Schedule C-1 - Management Services	17
C.	Expenditures Other than Salaries (Cont'd) - Dietary	18
C.	Expenditures Other than Salaries (Cont'd) - Laundry	19
C.	Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
	Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C.	Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
	Depreciation Schedule	23
	Amortization Schedule	24
C.	Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C.	Expenditures Other than Salaries (Cont'd) - Interest	26
C.	Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D.	Adjustments to Statement of Expenditures	28
D.	Adjustments to Statement of Expenditures (Cont'd)	29
F.	Statement of Revenue	30
G.	Balance Sheet	31
G.	Balance Sheet (Cont'd)	32
G.	Balance Sheet (Cont'd)	33
G.	Balance Sheet (Cont'd)	34
G.	Balance Sheet (Cont'd) - Reserves and Net Worth	35
H.	Changes in Total Net Worth	36
I.	Preparer's/Reviewer's Certification	37

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 Montowese Health & Rehabilitation Center	Period Covered:	From 10/1/2020	To 9/30/2021
Address of Facility 163 Quinnipiac Avenue, North Haven, CT 06473			
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
203-624-3303	9/30/2021	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Montowese Health & Rehabilitation Center	163 Quinnipiac Avenue, North Haven, CT 06473

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2442			07-5017

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.:
Donna C. Orefice	1677

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
Montowese Health & Rehabilitation Center	2442	9/30/2021	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned
Lawrence G Santilli	135 South Rd Farmington, CT 06032	President	0.62

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	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
Montowese Health & Rehabilitation Center	2442	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
Montowese Health & Rehabilitation Center	2442	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	%**				
Montowese Landlord LLC	135 South Rd, Farmington, CT 06032	○	⦿		Lease of Property	Pg 22 L9	975,844	975,844
Athena Health Care Assoc 401k Plan	135 South Rd, Farmington, CT 06032	○	⦿		Facility participates in common 401k plan			
Athena Health Care System	135 South Rd, Farmington, CT 06032	⦿	○	<50%	see attached		147,683	147,683
Procare Pharmacy	111 Executive Blvd, Farmingdale, NY 11735	⦿	○	>50%	Pharmacy Services	pg 20 5a2, 5b,	829,593	829,593
		⦿	○					
		○	⦿					
		⦿	○					
		⦿	○					
		○	⦿					

* 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
Montowese Health & Rehabilitation Center	2442	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.

Not Applicable

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

Not Applicable

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
Montowese Health & Rehabilitation Center	2442	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
Pitney Bowes, PO Box 371887, Pittsburgh, PA 15250	○	⦿	Mail Machine	01/31/18	63	2,131	2,131
Xerox, PO Box 202882, Dallas, TX 75320-2882	○	⦿	Copier	12/08/20	36	16,361	16,930
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					

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

Total *** 19,061

* 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
Montowese Health & Rehabilitatio	2442	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	185 Asylum St, 17th Floor, Hartford, CT 06103
2	Marcum, LLP	
3	Marcum, LLP	
4		

Services Provided by This Firm (*describe fully*)

	Service		Amount
1	Audit & Tax 2020: Allow	$	27,650
2	Audit & Tax Prior Years: Disallowed	$	32,292
3	Medicare Cost Report	$	2,700
4	PPP Loan: Disallow	$	9,270
	Charge for Services Provided	$	71,912

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

⦿ Yes ○ No Pg 15, Line1d

Legal Services Information

	Name of Legal Firm or Independent Attorney	Telephone Number
1	Murtha Cullina	203-772-7700
2	Timothy Wall/Heidell, Pittoni, Murphy & Bach	203-265-7173
3	Treasurer State of CT/ Reid & Reige	
4	Goldman, Gruder & Woods/Pilicy & Ryan	203-899-8900
5	Jackson Lewis PC	914-872-8060

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

1 265 Church Street, New Haven, CT 06510
2 PO Box 297, Wallingford, CT 06492
3
4 200 Connecticut Avenue, Norwalk, CT 06854
5 44 South Broadway 14th Fl, White Plains, NY 10601

Services Provided by This Firm (*describe fully*)

	Service		Amount
1	General Matter: allow	$	3,099
2	Conservatorship:Disallow	$	360
3	Conservatorship:Disallow	$	1,337
4	collections:Disallow	$	10,565
5	Employee Matters: Disallow	$	8,575
	Charge for Services Provided	$	23,936

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

⦿ Yes ○ No Pg 15, Line1e

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
Montowese Health & Rehabilitation Center	2442	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	120	120			120	120						
B. On last day of THIS report period	120	120							120	120		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	90	90			90	90						
B. As of midnight of THIS report period	116	116							116	116		
3. Total Number of Days Care Provided During Period												
A. Medicare	13,605	13,605			9,665	9,665			3,940	3,940		
B. Medicaid (Conn.)	18,961	18,961			13,409	13,409			5,552	5,552		
C. Medicaid (other states)												
D. Private Pay	1,758	1,758			1,178	1,178			580	580		
E. State SSI for RCH												
F. Other (Specify) Contract Other/VA	1,717	1,717			1,390	1,390			327	327		
G. Total Care Days During Period (3A thru F)	36,041	36,041			25,642	25,642			10,399	10,399		
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			59	59			38	38		
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	36,138	36,138			25,701	25,701			10,437	10,437		

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
Montowese Health & Rehabilitation Center	2442	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	25	64		8		19		
Per Diem Rate								
a. One bed rm.	581.70	293.83		600.00		430.87		
b. Two bed rms.	581.70	293.83		550.00		430.87		
c. Three or more bed rms.	581.70	293.83		500.00		430.87		

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	14,554	14,554		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	5,099	5,099		
2. Restorative Treatments				
C. Other	36,243	36,243		
D. ***Total Physical Therapy Treatments***	55,896	55,896		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	1,659	1,659		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	551	551		
2. Restorative Treatments				
C. Other	2,440	2,440		
D. ***Total Speech Therapy Treatments***	4,650	4,650		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	15,761	15,761		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	5,224	5,224		
2. Restorative Treatments				
C. Other	35,829	35,829		
D. ***Total Occupational Therapy Treatments***	56,814	56,814		

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
Montowese Health & Rehabilitation Center	2442	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)	123,558	2,081				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	352,799	14,113				
5. Dietary Service						
a. Head Dietitian	48,682	1,242				
b. Food Service Supervisor	66,295	2,110				
c. Dietary Workers	415,208	26,080				
6. Housekeeping Service						
a. Head Housekeeper	84,235	2,513				
b. Other Housekeeping Workers	337,852	22,981				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	70,962	2,085				
b. Other Maintenance Workers	87,683	4,267				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	105,400	7,422				
9. Barber and Beautician Services						
10. Protective Services	40,848	2,452				
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	200,458	3,130				
b. RN						
1. Direct Care	422,009	17,456				
2. Administrative**	1,091,539	33,493				
c. LPN						
1. Direct Care	1,224,009	46,946				
2. Administrative**						
d. Aides and Attendants	1,238,314	80,388				
e. Physical Therapists	1,241,277	32,147				
f. Speech Therapists	167,241	4,315				
g. Occupational Therapists	986,858	25,432				
h. Recreation Workers	134,939	7,146				
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	457,419	15,207				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	8,897,585	353,006				

* 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
Montowese Health & Rehabilitation Center	2442	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
Montowese Health & Rehabilitation Center	2442	9/30/2021	12	37

Name	Salary Paid: CCNH	Salary Paid: RHNS	Salary Paid: (Specify)	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
Section III - Administrators* **										
Donna C. Orefice	123,558			Health & Life Insuracne, Payroll Taxes	Day to day operations if the nursing home facility	2,081	A2			
10/1/20-9/30/21										
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
Montowese Health & Rehabilitation Center	2442	9/30/2021	13	37

Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
	Total Cost and 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	3,240	60				
3. Pharmacist	15,994	373				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	60,000	232				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting						
c. Resident Care**	179					
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	4,830	13				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	225,909	1,667				
2. Administrative***						
b. LPN						
1. Direct Care	388,081	6,122				
2. Administrative***						
c. Aides	1,209,954	15,331				
d. Other						
12. Other (Specify)						
See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	1,908,187	23,798				

* 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
Montowese Health & Rehabilitation Center	2442	9/30/2021	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Dr. Anuruddha Walaliyadda, 12 Cooke Road, Wallingford, CT 06492	Physician-Medical Director	○	◉	
Dr. Dharini Sun, 2690 Whitey Avenue, Hamden, CT 06518	Physician-Medical Director	○	◉	
Southern Connecticut Vascular Center, LLC, 495 Hawley Lane, Suite 2A, Stratford, CT 06614	Physician	○	◉	
Norton & Associates, 97 Elm St, Cohasset, MA 02025	RN, LPN, C.N.A. Pool	○	◉	
Solomon Page Staffing Solutions, 260 Madison Ave 4th Fl, New York, NY 10016	RN, LPN, C.N.A. Pool	○	◉	
Mas Medical Staffing, 156 Harvey Rd, Londonderry, NH 03053	LPN, C.N.A Pool	○	◉	
SDX Dysphagia Experts, 21 Waterville Rd, Avon, CT 06001	Speech Therapy	○	◉	
Healthdrive Dental Group, 888 Worcester St., Wllesley, MA 02482	Dentist	○	◉	
Procare LTC Pharmacy, 110 Bi-County Blvd, Ste 121, Farmingdale, NY 11735	Pharmacist	◉	○	Common Owners: Minority Interest
Yale New Haven Hospital, P.O. Box 780406, Philadelphia, PA 19178	Physician	○	◉	
Dedicated Nursing Associates Inc, 6536 William Pen Hwy, Rt 22 Suite 201, Delmont, PA 15626	C.N.A Pool	○	◉	
Five Star Care, 410 Melville Ave, Lakewood, NJ 08701	C.N.A Pool	○	◉	
Quest Diagnostic, 3404 Collection Center Drive, Chicago, IL 60693	Physician	○	◉	
Paramount Healthcare Services, Inc, 3 Courthouse Lane, Unit 2, Chelmsford, MA 01824	C.N.A Pool	○	◉	
		○	◉	
		○	◉	
		○	◉	
		○	◉	
		○	◉	
		◉	○	
		○	◉	
		○	◉	

* 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
Montowese Health & Rehabilitation Center	2442	9/30/2021	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	162,819	162,819		
2. Disability Insurance	$				
3. Unemployment Insurance	$	105,858	105,858		
4. Social Security (F.I.C.A.)	$	516,236	516,236		
5. Health Insurance	$	880,252	880,252		
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	29,872	29,872		
8. Uniform Allowance	$				
9. Other (*Specify*) See Attached Schedule	$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans forOwners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	170,170	170,170		
d. Accounting and Auditing	$	71,912	71,912		
e. Legal (*Services should be fully described on Page 7)*	$	23,936	23,936		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	61,965	61,965		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	10,310	10,310		
2. Cellular Phones	$	1,399	1,399		
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*	$	500	500		
2. Other (*Specify*) See Attached Schedule	$				
3. Resident Day User Fee	$	472,361	472,361		
Subtotal	$	2,507,590	2,507,590		

* 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**

Attachment Page 15

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
Montowese Health & Rehabilitation Center	2442	9/30/2021	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,507,590	2,507,590		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	6,706	6,706		
3. Gifts to Staff and Residents	$	7,550	7,550		
4. Employee Travel	$	4,744	4,744		
5. Education Expenses Related to Seminars and Conventions	$	18,697	18,697		
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*)	$	39,180	39,180		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	6,751	6,751		
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	$	7,015	7,015		
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	9,056	9,056		
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	625	625		
10. Contributions***	$				
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**	$	3,530	3,530		
13. Other (*Specify*)	$	142,037	142,037		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,753,481	2,753,481		

* 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	$ 6,751		
Total Other Advertising	$ 6,751	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF Dues	$ 7,856		
AHCA	$ 1,200		
Total Dues	$ 9,056	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
	$ -		
Bank Charges	$ 36,394		
Payroll Processing Fees	$ 25,281		
Employee Physicals/Background Checks	$ 8,992		
Data Processing/ Software Maint. Fees	$ 58,201		
Facilities Comp Fire Consulting Fees	$ 9,919		
Penatlies-Civil Money Penalty IRS Citation 2021-01-LTC-419	$ 3,250		
Total Other Administrative and General	$ 142,037	$ -	$ -

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

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health & Rehabilitation Cent	2442	9/30/2021	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	5,349	Contract Attached to a Prior Year	See Below
Allocation of the above	3,530	Admin/Gen 66%	Pg 16, Line 12
Allocation of the above	856	Indirect 16%	Pg 20 Line 5k
Allocation of the above	963	Direct 18%	Pg 20 Line 5j

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health & Rehabilitation Center	2442	9/30/2021	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	345,950	345,950		
2. Non-Food Supplies	$	33,170	33,170		
3. Other (*Specify*) Dishes	$	3,953	3,953		
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)	$	383,073	383,073		

2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	296	296		

	Question	Yes	No		
G.	Is cost of employee meals included in 2D?	⦿ Yes	○ No		
H.	Did you receive revenue from employees?	⦿ Yes	○ No	If yes, specify amt.	$1,589
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				Pg 18 2a1
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.

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
Montowese Health & Rehabilitation Center	2442	9/30/2021	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	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. $	19,266	19,266		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*) Supplies	$	7,184	7,184		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	26,450	26,450		

	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
Montowese Health & Rehabilitation Center	2442	9/30/2021	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping a. In-House Care	Sq. Ft. Serviced by Personnel					
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	20,893	20,893		
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)		$	20,893	20,893		
5. Resident Care (Supplies)** a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Procare		$	807,851	807,851		
b. Medicine Cabinet Drugs		$	8,764	8,764		
c. Medical and Therapeutic Supplies		$	479,915	479,915		
d. Ambulance/Limousine***		$	307	307		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	32,803	32,803		
f. X-rays and Related Radiological Procedures***		$	59,410	59,410		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	132,646	132,646		
i. Recreation		$	12,165	12,165		
j. Direct Management Services*		$	963	963		
k. Indirect Management Services*		$	856	856		
l. Other (Specify)**** See Attached Schedule		$	167,691	167,691		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	1,703,371	1,703,371		

* 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)
	$ -		
Cable TV	$ 34,543		
Medical Equip Rentals-Medicaid	$ 39,149		
Occupational Therapy Supplies	$ 4,715		
Oxygen Equipment Rentals	$ 42,883		
Physical Therapy Supplies	$ 12,555		
Medical Equip Rentals-Other	$ 33,846		
Total Other Resident Care	$ 167,691	$ -	$ -

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
Montowese Health & Rehabilitation Center	2442	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
CWPM, LLC	25 Norton Place, Plainville, CT 06062	○	⊙		Rubbish Removal	36,758			22	6f
Procare LTC Pharmacy	111 Excutive Blvd Farmingdale NY 11735	⊙	○	Common Owners: Minority Interest	Pharmacy Services	829,593			20	5A2 &
ADP	PO Box 842875, Boston, MA 02284-2875	○	⊙		Payroll Processing	22,134			16	m13
Executive Landscaping	PO Box 185790, Hamden, CT 06518	○	⊙		Landscaping and Snow Removal Services	43,649			22	6f
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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).

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Groundskeeping	$ 45,104		
Rubbish Removal	$ 38,442		
	$ -		
Supplies	$ 70,885		
Total Other Repairs and Maintenance	$ 154,431	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health & Rehabilitation Center	2442	9/30/2021	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	123,688	123,688		
b. Heat	$	58,081	58,081		
c. Light & Power	$	123,738	123,738		
d. Water	$	43,870	43,870		
e. Equipment Lease (*Provide detail on page 6*)	$	19,061	19,061		
f. Other (*itemize*)	$	154,431	154,431		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	522,869	522,869		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$				
d. Movable Equipment	$	147,279	147,279		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	147,279	147,279		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$	611,745	611,745		
b. Mortgage Expense	$				
c. Leasehold Improvements	$	19,669	19,669		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	631,414	631,414		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	975,844	975,844		
10. Property Taxes					
a. Real estate taxes paid by owner	$	193,782	193,782		
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	14,204	14,204		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,962,523	1,962,523		

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

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
Montowese Health & Rehabilitation Center	2442	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	734,257			373,591	S/L	Various	144,595	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2021	41,535				S/L	Various	2,684	
D-3. Subtotal												147,279
E. ***Total Depreciation***												147,279

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	Triplestitch-white boards	$ 3,373	5	$ 337	
12/31/2020	Triplestitch-white boards	$ 3,428	5	$ 343	
5/31/2021	HPC-Ice Machine	7461	10	373.05	
5/31/2021	Daniels Equipment-Unimac Washer	14349	10	717.45	
7/31/2021	Next Gen-Office Chairs	5209	10	260.45	
Various	See Attached	7715		653	
Total additions for Movable Equipmen		$ 41,535		$ 2,684	*
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:					
5/31/2021	Write Way Signs-Signs	$ 2,065	10	$ 103	
5/31/2021	Air Temp-Compressor	$ 2,550	10	$ 128	
5/31/2021	Air Temp-Control Board	2683	10	134.15	
1/31/2021	FCS-Smoke Detectors	2994	20	74.85	
12/31/2020	Air Temp-Acuators	2717	10	135.85	
Various	Additional Purchases	113179		2906	
Total additions for Leasehold Improvemer		$ 126,188		$ 3,482	*
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
Montowese Health & Rehabilitation Center	2442	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. Organization Expense	Jan	2018	10 years	6,059,160	1,539,446	S/L		611,745	
2.									
3.									
A-4. Subtotal									611,745
B. **Mortgage Expense**									
1. Finance Fees-Key Bank									
2. Finance Fees									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period		2020		187,123	29,144	S/L	Variou	16,187	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2021	Various	126,188			Variou	3,482	
C-4. Subtotal									19,669
D. ***Total Amortization***									631,414

* 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	License No.	Report for Year Ended	Page of
Montowese Health & Rehabilitation C	2442	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	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	120
6. Square Footage	
7. Acquisition Cost	
a. Land	200,000
b. Building	9,020,872

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Conventional			
b. Date Mortgage Obtained	01/25/18			
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	12,800,000			
f. Principal balance outstanding as of ___9/30/2021	12,154,750			
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
Montowese Health & Rehabilitation C	2442	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
Montowese Health & Rehabilitation	2442	9/30/2021	27 | 37

Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment 1. Automotive Equipment			$				
A. Item	Rate	Amount					
Lender							
Address of Lender							
2. Other (*Specify*)			$				
A. Item	Rate	Amount					
Lender							
Address of Lender							
B. Item	Rate	Amount					
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)			$				
12. D. Other Interest Expense (*Specify*) Vendor Interest=$14,276			$	14,276	14,276		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)			$	14,276	14,276		
14. Insurance a. Insurance on Property (buildings only)			$	127,168	127,168		
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)***			$	127,168	127,168		
15. ***Total All Expenditures (A-13 thru C-14)***			$	18,319,876	18,319,876		

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
Montowese Health & Rehabilitation Center	2442	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	$	986,858	986,858		
4.			Other - See attached Schedule	$	2,157	2,157		
Page 13 - Professional Fees								
5.			Resident Care Physicians **	$	179	179		
6.			Occupational Therapy	$				
7.			Other - See attached Schedule	$				
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.			Bad Debts	$	170,170	170,170		
10.			Accounting	$	44,661	44,661		
10a.			Legal	$	20,837	20,837		
11.			Telephone	$				
12.			Cellular Telephone	$	1,039	1,039		
13.			Life insurance premiums on the life of Owners, Partners, Operators	$				
14.			Gifts, flowers and coffee shops	$	7,550	7,550		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	$	9,223	9,223		
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 *	$	6,751	6,751		
19.			Income Tax / Corporate Business Tax	$	500	500		
20.			Fund Raising / Contributions	$				
21.	16	m12	Unallowable Management Fees	$	(179,154)	(179,154)		
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$	49,563	49,563		
Page 18 - Dietary Expenditures								
24.			Meals to employees, guests and others who are not residents	$	3,393	3,393		
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)	$	1,123,727	1,123,727		

* 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	Marketing Salaries & Benefits	$ 2,157		
Total Other Salaries Adjustment			$ 2,157	$ -	$ -

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	$ 36,394		
16	M13	Penalties-Civil Money Penalty IRS Penalty Citation 2021-01-LTC-419	$ 3,250		
16	M13	Prior Year Facility Consulting Fees	$ 9,919		
Total Other A&G Adjustments			$ 49,563	$ -	$ -

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
Montowese Health & Rehabilitation Center	2442	9/30/2021	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	1,123,727	1,123,727		
Page 20 - Resident Care Supplies*								
27.			Prescription Drugs	$	807,851	807,851		
28.			Ambulance/Limousine	$	307	307		
29.			X-rays, etc	$	59,410	59,410		
30.			Laboratory	$	132,646	132,646		
31.			Medical Supplies	$	13,920	13,920		
32.			Oxygen (non emergency)	$	32,803	32,803		
33.			Occupational Therapy	$	4,715	4,715		
34.			Other - See Attached Schedule	$	64,789	64,789		
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$	65,308	65,308		
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.	$	1,395	1,395		
44.			Other - Miscellaneous Administrative	$				
45.	20	5j	Management Fees Direct	$	(48,860)	(48,860)		
46.	20	5k	Management Fees Indirect	$	(43,431)	(43,431)		
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)***	$	2,214,580	2,214,580		

*** 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	$ 33,846		
20	5j	Radio + Television Revenue	$ 30,943		
Total Other Ancillary Costs			$ 64,789	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excluded Movable Equipment (See Attached)	$ 65,308		
Total Excess Movable Equipment Depreciation			$ 65,308	$ -	$ -

---

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)
Total Other Adjustments			$ -	$ -	$ -

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
Montowese Health & Rehabilitation Cent	2442	9/30/2021	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	9,634,577	9,634,577		
b. Medicaid Room and Board Contractual Allowance **	$	(4,411,085)	(4,411,085)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	4,108,012	4,108,012		
b. Medicare Room and Board Contractual Allowance **	$	1,001,977	1,001,977		
4. a. Private-Pay Residents and Other	$	4,335,290	4,335,290		
b. Private-Pay Room and Board Contractual Allowance **	$	(136,213)	(136,213)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	404,103	404,103		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(404,103)	(404,103)		
c. Prescription Drugs - Non-Medicare	$	491,799	491,799		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(491,799)	(491,799)		
2. a. Medical Supplies - Medicare	$	1,920	1,920		
b. Medical Supplies - Medicare Contractual Allowance **	$	(760)	(760)		
c. Medical Supplies - Non-Medicare	$	1,606	1,606		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(1,606)	(1,606)		
3. a. Physical Therapy - Medicare	$	1,797,935	1,797,935		
b. Physical Therapy - Medicare Contractual Allowance **	$	(1,349,729)	(1,349,729)		
c. Physical Therapy - Non-Medicare	$	1,051,740	1,051,740		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(1,051,740)	(1,051,740)		
4. a. Speech Therapy - Medicare	$	365,100	365,100		
b. Speech Therapy - Medicare Contractual Allowance **	$	(244,661)	(244,661)		
c. Speech Therapy - Non-Medicare	$	259,125	259,125		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(259,125)	(259,125)		
5. a. Occupational Therapy - Medicare	$	1,814,540	1,814,540		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(1,360,741)	(1,360,741)		
c. Occupational Therapy - Non-Medicare	$	1,081,950	1,081,950		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(1,081,950)	(1,081,950)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	1,135,782	1,135,782		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	16,691,944	16,691,944		
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)*	$	1,395	1,395		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	8,113	8,113		
V. Total Other Revenue (1 thru 8)	$	9,508	9,508		
VI. Total All Revenue (III +V)	$	16,701,452	16,701,452		

* *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)
	Retroactives	$ (20,523)		
	Misc Revenue from CRF funding	$ 1,156,305		
Total Other Resident Revenue		$ 1,135,782	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
pg 31, L A1	Interest on A/R		$ 1,395		
Total Interest Income			$ 1,395	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Bad Debt Recoveries	$ 8,113		
Total Other Revenue		$ 8,113	$ -	$ -

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
Montowese Health & Rehabilitation Ce	2442	9/30/2021	31	37

Account			Amount
Assets			
A. Current Assets			
1. Cash (*on hand and in banks*)			$ 336,758
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			$ 1,900,487
3. Other Accounts Receivable (Excluding Owners or Related Parties)			$ 3,955
4 Inventories			$ 23,450
5. Prepaid Expenses			$ 425,111
a. Prepaid Insurance		131,393	
b. Prepaid Health Insurance		38,849	
c. Prepaid Tax, Rent and Other		248,030	
d. See Schedule		6,839	
6. Interest Receivable			$
7. Medicare Final Settlement Receivable			$ (646,065)
8. Other Current Assets (*itemize*)			$ 167,009
AR Related Party		167,009	
See Schedule			
A-9. ***Total Current Assets*** (Lines A1 thru 8)			$ 2,210,705
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	313,311	$ 264,498
	Accum. Depreciation	48,813 Net	
5. Non-Movable Equipment	*Historical Cost		$
	Accum. Depreciation	Net	
6. Movable Equipment	*Historical Cost	350,553	$ (170,318)
	Accum. Depreciation	520,871 Net	
7. Motor Vehicles	*Historical Cost		$
	Accum. Depreciation	Net	
8. Minor Equipment-Not Depreciable			$
9. Other Fixed Assets (*itemize*)			$ 444,269
Moveable Equipment Carryforward		425,241	
See Schedule		19,028	
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)			$ 538,449

* 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 Expenses	$ 6,839
Total Prepaid Expenses			$ 6,839

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	
		Project Development	$ 19,028
Total Other Other Fixed Assets (Itemize)			$ 19,028

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		0	$ -
		0	$ -
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

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

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

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

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
Montowese Health & Rehabilitation Ce	2442	9/30/2021	32	37

Account					Amount
				Total Brought Forward:	$ 2,749,154
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	6,059,160		
		Accum. Depreciation	2,151,191	Net	$ 3,907,969
	4. Goodwill (Purchased Only)				$ (16,134)
	5. Investments Related to Resident Care (*itemize*)				$
	6. Loans to Owners or Related Parties (*itemize*)				$
	Name and Address	Amount	Loan Date		
	7. Other Assets (*itemize*)				$ 165,543
	Start Up Costs		165,543		
	See Schedule				
D-8.	***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 4,057,378
D-9.	***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 6,806,532

* 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
Montowese Health & Rehabilitation Center	2442	9/30/2021	33 | 37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 3,901,550
2. Notes Payable (*itemize*)				$ 3,724,398
Due From Related Party		3,724,398		
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*)				$ 505,810
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 375,592
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*)				$ 368,939
		Provider Taxes Due	680,152	
Accrued Health Insurance	16,335			
Acc'd Operating Expenses	263,135	Due to/From Related Par	(591,479)	
Acc'd Expense - Sales Tax	796	See Schedule		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 8,876,289

* 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
Montowese Health & Rehabilitation Center	2442	9/30/2021	34 | 37

Account	Amount
Total Brought Forward:	8,876,289
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

Account	Amount
2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$ 3,078,775

Name and Address of Lender	Amount	Loan Date
Due to Partnership	3,113,869	
Note Pay-McKesson	(35,094)	

Account	Amount
4. Other Long-Term Liabilities (*itemize*) Notes Payable Related Landlord See Schedule	$
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 3,078,775
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 11,955,064

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
Montowese Health & Rehabilitation Ce	2442	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					$ 3,375,000
4. Treasury Stock					$
5. Cumulated Earnings					$ (6,905,108)
6. Gain or Loss for Period	10/1/2020	thru	9/30/2021		$ (1,618,424)
7. Total Net Worth					$ (5,148,532)
C. ***Total Reserves and Net Worth***					$ (5,148,532)
D. ***Total Liabilities, Reserves, and Net Worth***					$ 6,806,532

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
Montowese Health & Rehabilitation Cen	2442	9/30/2021	36 | 37

	Account			Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2020			$ (2,492,495)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 16,701,452
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 18,319,876
D.	Net Income or Deficit			$ (1,618,424)
E.	Balance			$ (4,110,919)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Health Insurance 2020	(311,950)		
	2020 Fixed Asset Correction	(1,423)		
	2020 Nurse Pool expense accrual	(67,521)		
		(656,719)		
	2. Other (*itemize*)			
F-3.	Total Additions			$ (1,037,613)
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			$ (5,148,532)

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	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