State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2020

Name of Facility (as licensed) FILOSA FOR NURSING AND REHABILITATION		
Address (No. & Street, City, State, Zip Code) 13 HAKIM STREET, DANBURY, CT. 06810		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	461-C	0	0	07-5074

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	4614	0	0

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)	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2020	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.

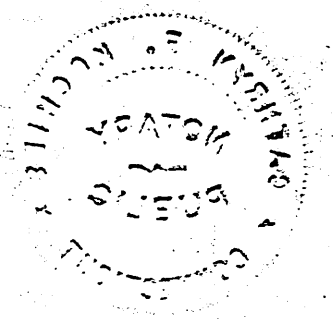
I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for FILOSA FOR NURSING AND REHABILITATION [facility name], for the cost report period beginning October 1, 2019 and ending September 30, 2020, and that to the 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
			Barbara A Malone	8/15/21
Printed Name (Administrator) MICHAEL D. MALONE			Printed Name (Owner) BARBARA A. MALONE	
Subscribed and Sworn to before me:	State of Connecticut	Date	Signed (Notary Public) Cathryn F Kachies	Comm. Expires 03/31/2022
Address of Notary Public 191 Westville Ave Ext Danbury, CT 06811				

(Notary Seal)



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

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Name of Facility FILOSA FOR NURSING AND REHABILITATION	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 13 HAKIM STREET, DANBURY, CT. 06810				
Report Prepared By	Phone Number		Date	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$	0	0	0	0
2. Laundry wages paid	$	0	0	0	0
3. Housekeeping wages paid	$	0	0	0	0
4. Nursing wages paid	$	0	0	0	0
5. All other wages paid	$	0	0	0	0
6. ***Total Wages Paid***	$	0	0	0	0
7. Total salaries paid	$	0	0	0	0
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$	0	0	0	0

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.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-744-3666	9/30/2020	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
FILOSA FOR NURSING AND REHABILITATION	13 HAKIM STREET, DANBURY, CT. 06810

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	461-C	0	0	07-5074

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.:
MICHAEL D. MALONE	001685

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILIT	461-C	9/30/2020	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
FILOSA CONVALESCENT HOME, INC	13 HAKIM STREET, DANBURY, CT 06810	CONNECTIC UT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
FRANK D. MALONE	105 MIDDLE RIVER ROAD, DANBURY, CT 06811	TREASURER	122
BARBARA A. MALONE	105 MIDDLE RIVER ROAD, DANBURY, CT 06811	SECRETARY	491
JENNIFER MALONE-SEIXAS	592 MANVILLE ROAD, PLEASANTVILLE, NY 10570	PRESIDENT	125
MICHAEL D. MALONE	197 GUINEA ROAD, MONROE, CT 06468	ICE-PRESIDEN	129
JOHN M. MALONE	22 NORTH DUTCHER STREET, IRVINGTON, NY 10533	DIRECTOR	119
Names of Stockholders Owning at Least 10% of Shares			
FRANK D. MALONE	105 MIDDLE RIVER ROAD, DANBURY, CT 06811	TREASURER	122
BARBARA A. MALONE	105 MIDDLE RIVER ROAD, DANBURY, CT 06811	SECRETARY	491
JENNIFER MALONE-SEIXAS	592 MANVILLE ROAD, PLEASANTVILLE, NY 10570	PRESIDENT	125
MICHAEL D. MALONE	197 GUINEA ROAD, MONROE, CT 06468	ICE-PRESIDEN	129
JOHN M. MALONE	22 NORTH DUTCHER STREET, IRVINGTON, NY 10533	DIRECTOR	119

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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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	%**				
FILOSA CARE CENTER DBA HANCOCK HALL	31 STAPLES ST., DANBURY, CT 06811	○	⊙	0%	SHARED EXPENSES	SEE ATTACHED	SEE ATTAC	0
BARBARA A. MALONE (BAMCO, LLC)	105 MIDDLE RIVER ROAD, DANBURY, CT 06811	○	⊙	0%	BUILDING RENTAL/DEPRECIATION	22/9 22/7b	780,000	780,000
SPACE PANTS, LLC	197 GUINEA ROAD, MONROE, CT 06468	○	⊙	0%	PARKING LOT RENTAL	22/9	8,100	8,100
SPACE PANTS, LLC	197 GUINEA ROAD, MONROE, CT 06468	○	⊙	0%	OFF SITE STORAGE	22/9	6,480	6,480
MICHAEL MALONE	197 GUINEA ROAD, MONROE, CT 06468	○	⊙	0%	ADMINISTRATOR	10/A2	78,977	78,977
FILOSA CARE CENTER DBA HANCOCK HALL	31 STAPLES ST., DANBURY, CT 06811	○	⊙	0%	ADVANCED FUNDS	34/B3	(81,624)	(81,624)
		○	⊙	0%				
		○	⊙	0%				
		○	⊙	0%				

* Use additional sheets if necessary.

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

FILOSA FOR NURSING AND REHABILITATION
COST YEAR 2020
LICENSE NO 461-C

ATTACHMENT TO PAGE 4 OF 37 GENERAL INFORMATION AND QUESTIONAIRE

Name of Related Individual or Company	Description of Goods / Services Provided		Costs are Included in Annual Report Page# / Line#	FCH Portion	HH Portion
HANCOCK HALL 31 STAPLES STREET, DANBURY, CT 06810	THE FACILITY SHARES A NON-DISCRIMINATORY PENSION PLAN, WITH HANCOCK HALL. WITH EACH FACILITY PAYING THEIR SHARE	Actual	15.1.A.9.D	$7,245	$19,057
	401K FINANCIAL STATEMENT AUDIT	*	15.1.A.9.D	$2,800	$4,200
	INSURANCE IN CONJUNCTION WITH HANCOCK HALL				
HANCOCK HALL 31 STAPLES STREET, DANBURY, CT 06810	VARIOUS INSURANCES				
	WORKMENS COMPENSATION	*	15.1.A.1	$77,369	$113,530
	DISABILITY	Actual	15.1A.2	$16,005	$21,804
	HEALTH AND DENTAL	Actual	15.1.A.5	$315,972	$434,584
	PROPERTY:				
	INSURANCE ON PROPERTY	*	27.14.A	$2,974	$4,441
	INSURANCE OF AUTOMOBILES	*	27.14.B	$3,003	$4,888
	UMBRELLA	*	27.14.C.1	$8,398	$12,600
	FIRE AND EXTENDED COVERAGE	*	27.14.C.2	$31,378	$49,794
	FIDUCIARY	*	27.14.C.3	$0	
	DIRECTORS AND OFFICER	*	27.14.C.3	$8,352	$11,851
	CYBER LIABILITY	*	27.14.C.3	$1,904	$2,856
			TOTAL PROPERTY INS	$56,008	$86,430
	BOTH HANCOCK HALL & FILOSA CONVALESCENT HOME, SHARE THE WAGES OF THESES EMPLOYEES				
HANCOCK HALL 31 STAPLES STREET, DANBURY, CT 06810	SHARED EMPLOYEE WAGES:				
	HEAD ACCOUNTANT'S (1)	*	10.11.A	$34,799	$76,941
	OTHER ACCOUNTANTS (5)	*	10.A6.B	$71,487	$148,834
	HEAD HOUSEKEEPER (1)	**	10.A.6.A	$34,799	$50,076
	ENGINEER OR CHIEF OF MAINTENANCE (1)	**	10.A.7.A	$44,487	$63,989
	FOOD SERVICE SUPERVISOR (1)	*	10.A5.B	$32,830	$49,244
	RN - ADMINISTRATIVE (1)	Actual	10.A.12.B.2	$0	
	LPN - ADMINISTRATIVE (1)	Actual	10.A.12.C.2	$0	
	OTHER ADMINISTRATIVE SALARIES (1)	*	10.A.4	$29,607	$44,410
	RECREATION DIRECTOR	*	10.A.12.H	$25,772	$38,658
	RECREATION WORKERS	Actual	10.A.12.H	$83,574	$112,390
			TOTAL WAGES	$357,333	$584,543
HANCOCK HALL 31 STAPLES STREET, DANBURY, CT 06810	VEHICLE EXPENSES-BOTH HANCOCK HALL & FILOSA CONVALESCENT HOME SHARE, USE OF THE COMPANY UTILITY TRUCK & VAN. EXPENSES FOR VAN ON HANCOCK AND EXPENSES FOR TRUCK ON FILOSA	Actual	16.L.7	$1,207	$515
HANCOCK HALL	TELEPHONE AND INTERNET	*	15.1HI	$10,241	$14,611
31 STAPLES STREET, DANBURY, CT 06810	TELEPHONE SYSTEM INTEREST	*	22.7.D	$797	$1,128

* Allocated according to the facilities ratio of its beds to 160- the combined total of bot Hancock Hall and Filosa. Under this method of allocation Hancock is charged 60% (96/160) of expense while Filosa is charged 40% (64/160).

** Allocated according to the facilities rationof it's square footage to 95,905 square feet. - the combined square footage of both Hancock Hall & Filosa. Under this method of allocation Hancock Hall is charged 59% (56,300/95,905) of expense while Filosa is charged 41% (39,605/95,905)

*** Allocated as follows: Billing and Census 80% Hancock Hall 20% Filosa. Accounting 60% Hancock Hall 40% Filosa

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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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 (*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.

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

SEE ATTACHED

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.

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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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
WELLS FARGO/RICOH USA , PO BOX 41554, PHILADELPHIA, PA 19101	O	⊙	COPIER MACHINE LEASE	08/01/18	60 MONTH LEASE	8,161	8,161
	O	⊙					
	O	⊙					
	O	⊙					
	O	⊙					
	O	⊙					
	O	⊙					
	O	⊙					
	O	⊙					
	O	⊙					
						Total ***	8,161

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

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

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
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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.

0

Independent Accounting Firm

	Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1	CLIFTON LARSON ALLEN, LLP	300 CROWN COLONY DRIVE, STE 310, QUINCY MA 02169
2	CLIFTON LARSON ALLEN, LLP	300 CROWN COLONY DRIVE, STE 310, QUINCY MA 02169
3		
4		

Services Provided by This Firm (*describe fully*)

1	COMPILATION FINANCIAL STATEMENT	$	7,500
2	401K AUDIT FINANCIALS STATEMENT	$	2,800
3		$	
4		$	

Charge for Services Provided: $ 10,300

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
◉ Yes ○ No 15/1/D

Legal Services Information

	Name of Legal Firm or Independent Attorney	Telephone Number
1	MICHALIK, BAUER, SILVIA & CICCARILLO, LLP	860-225-8403
2	MURTHA & CULLINA, LP	203-772-7728
3		
4		
5		

Address (*No. & Street, City, State, Zip Code*)
1 35 PEARL STREET, SUITE 300, NEW BRITAIN, CT, 06051-2645
2 265 CHURCH STREET, NEW HAVEN CT 06510
3
4
5

Services Provided by This Firm (*describe fully*)

1	COLLECTION SERVICES	$	9,969
2	CONSULTING	$	248
3		$	
4		$	
5		$	

Charge for Services Provided: $ 10,217

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
◉ Yes ○ No 15/1/E

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	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	64	64			64	64						
B. On last day of THIS report period	64	64							64	64		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	59	59			59	59						
B. As of midnight of THIS report period	55	55							55	55		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,732	1,732			1,337	1,337			395	395		
B. Medicaid (Conn.)	14,438	14,438			10,961	10,961			3,477	3,477		
C. Medicaid (other states)												
D. Private Pay	4,201	4,201			3,244	3,244			957	957		
E. State SSI for RCH												
F. Other (Specify) Managed Medicare	277	277			184	184			93	93		
G. Total Care Days During Period (3A thru F)	20,648	20,648			15,726	15,726			4,922	4,922		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	33	33			33	33						
B. Other Bed Reserve Days	31	31			31	31						
5. ***Total Resident Days*** **(3G + 4A + 4B)**	20,712	20,712			15,790	15,790			4,922	4,922		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILIT	461-C	9/30/2020	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)	
	X	X	X										
	X	X	X										
	X	X	X										
	X	X	X										

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	8	35		12				
Per Diem Rate								
a. One bed rm.	393.00			520.00				
b. Two bed rms.	702.00	261.96		490.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	3,014	3,014		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	4,133	4,133		
D. ***Total Physical Therapy Treatments***	7,147	7,147		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	6,689	6,689		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	9,405	9,405		
D. ***Total Speech Therapy Treatments***	16,094	16,094		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	3,326	3,326		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	4,800	4,800		
D. ***Total Occupational Therapy Treatments***	8,126	8,126		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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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)	78,977	2,299				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	100,170	4,642				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	32,830	896				
c. Dietary Workers	301,155	16,266				
6. Housekeeping Service						
a. Head Housekeeper	34,799	856				
b. Other Housekeeping Workers	162,948	11,783				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	44,467	856				
b. Other Maintenance Workers	68,384	2,318				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	72,871	4,202				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant	51,294	922				
b. Other Accountants	71,487	2,562				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	130,084	3,185				
b. RN						
1. Direct Care	630,421	18,187				
2. Administrative**	103,874	2,527				
c. LPN						
1. Direct Care	528,283	18,212				
2. Administrative**	770	26				
d. Aides and Attendants	1,054,266	59,270				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	109,346	4,353				
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	70,787	1,939				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	156,522					
A-13. Total Salary Expenditures	3,803,734	155,302				

* 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
COVID-19 RELATED WAGE INCENTIVE	$ 156,522					
Total	$ 156,522	-	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

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

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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
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2020	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										
JENNIFER MALONE-SEIXAS				SAMES AS OTHER EMPLOYEES	PRESIDENT			HANCOCK HALL 31 STAPLES ST DANBURY CT	2,236	189,220
MICHAEL MALONE				SAMES AS OTHER EMPLOYEES	VICE-PRESIDENT			HANCOCK HALL 31 STAPLES ST DANBURY CT		119,190
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).										

* 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.

FILOSA FOR NURSING AND REHABILITATION
COST YEAR 2020
LICENSE NO 461-C

ATTACHMENT TO PAGE 11C OF 37 GENERAL INFORMATION AND QUESTIONAIRE

OWNER SALARY

	HANCOCK			FILOSA			COMBINED TOTAL		FICA	
	HRS	SALARY		HRS	SALARY		HRS	SALARY	ALLOW	DISALLOW
JENNIFER MALONE-SEIXAS										
ADMINISTRATOR	2,236	91,610	SEE BELOW	-	-		2,236	91,610	-	-
PRESIDENT	-	97,610	Disallow	-	-	Disallow	-	97,610	-	-
	2,236	$ 189,220		-	$ -		2,236	$ 189,220		
MICHAEL MALONE										
ADMINISTISTRATOR	-	-		2,299	78,977		2,299	78,977	6,053	(11)
VICE-PRESIDENT	-	119,190	Disallow	-	-	Disallow	-	119,190	-	-
	-	119,190		2,080	$ 78,977		2,299	$ 198,167	$ 6,053	$ (11)

ADMINISTRATOR ALLOWANCE	Total	MAXIMUM ALLOWABLE						
		@60 Beds	Per Bed	#Beds	Excess	Amount Allowed Total Beds 96		
MICHAEL MALONE	$ 78,977	$ 77,591	383	4	$ 1,532	$ 79,123	$ (146)	No Disallowance

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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
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2020	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* **										
MICHAEL MALONE	78,977			SAMES AS OTHER EMPLOYEES	STAFF RESPONSIBLE FOR FACILTIY	2,299	A-2			
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.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATIO	461-C	9/30/2020	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	23,648	526				
2. Dentist	5,957	13				
3. Pharmacist	6,878	110				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	147,169	2,202				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	27,600	200				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)	866	5				
2. Pharmaceutical Committee (Quarterly meetings)	866	5				
3. Staff Development Committee (Once annually)	743	4				
e. Other (Specify)						
PSYCH RDS	10,800	61				
9. Speech Therapist						
a. Resident Care	34,660	360				
b. Other						
10. Occupational Therapist						
a. Resident Care	163,677	2,540				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	422,862	6,026				

* 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.

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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
FILOSA FOR NURSING AND REHABILITATIOI	461-C	9/30/2020	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
GRACE AHERN, R.D. 4 WESTMINSTER ROAD, DANBURY, CT, 06811	DIETICIAN - DIETARY NEEDS AND REPORTS	O	⊙	
SERAFIMA GLOUZGAL,MD, 388 GROVE ST, RIDGEFIELD, CT 06877	COORDINATION OF MEDICAL CARE FOR RESIDENTS	O	⊙	
HEALTH DRIVE DENTAL GROUP, 888 WORCHESTER ST, WELLESLEY, MA	EVALUATION AND DENTAL GROUP	O	⊙	
SYMBRIA REHAB, 28100 TORCH PARKWAY, WARRENVILLE, IL 60555	PT, OT AND SPEECH EVALUATIONS AND TREATMENT	O	⊙	
ORESTES ARCUNI, MD , 4 BARTRAM DRIVE, WEST REDDING, CT 06896	PSYCHIATRIC EVALUATIONS AND SERVICES	O	⊙	
REV. DAVID FRANKLIN, ST. JOSEPH'S ROMAN CATHOLIC CHURCH, 8 ROBINSON	MASS AND CLERGY VISITS TO FACILITY RESIDENTS	O	⊙	
OMNICARE PHARMACY, 525 KNOTTER DRIVE, CHESHIRE, CT	INFECTION CONTROL REVIEW, PHARMACEUTICAL REVIEW,	O	⊙	
		O	⊙	
		O	⊙	
		O	⊙	
		O	⊙	
		O	⊙	
		O	⊙	
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		O	⊙	
		O	⊙	
		O	⊙	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITAT	461-C	9/30/2020	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	77,369	77,369		
2. Disability Insurance	$	5,174	5,174		
3. Unemployment Insurance	$	36,985	36,985		
4. Social Security (F.I.C.A.)	$	269,860	269,860		
5. Health Insurance	$	305,141	305,141		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	7,245	7,245		
(not-owners and not-operators)					
8. Uniform Allowance	$	2,612	2,612		
9. Other (*Specify*)	$	16,849	16,849		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans forOwners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	24,000	24,000		
d. Accounting and Auditing	$	10,300	10,300		
e. Legal (*Services should be fully described on Page 7)*	$	10,216	10,216		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	21,430	21,430		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	8,130	8,130		
2. Cellular Phones	$	2,111	2,111		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$	250	250		
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$	94,648	94,648		
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	391,288	391,288		
Subtotal	$	1,283,608	1,283,608		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
PHYSICALS	$ 6,018		
DENTAL INSURANCE EXPENSE	$ 10,831		
Total	$ 16,849	$ -	$ -

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2020	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,283,608	1,283,608		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	2,245	2,245		
2. Holiday Parties for Staff	$	794	794		
3. Gifts to Staff and Residents	$	5,675	5,675		
4. Employee Travel	$				
5. Education Expenses Related to Seminars and Conventions	$	790	790		
6. Automobile Expense (*not purchase or depreciation*)	$	1,207	1,207		
7. Other (*Specify*) See Attached Schedule	$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	15,956	15,956		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$	10,050	10,050		
4. Fund-Raising***	$				
5. Medical Records	$	3,896	3,896		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	2,200	2,200		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	4,717	4,717		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	536	536		
10. Contributions*** See Attached Schedule	$	1,200	1,200		
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual*)	$	6,509	6,509		
12. Administrative Management Services**	$				
13. Other (*Specify*) See Attached Schedule	$	101,670	101,670		
C-14 Total Administrative & General Expenditures	$	1,441,054	1,441,054		

* 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)
PROMOTION-PUBLIC RELATIONS	$ 10,050		
Total Other Advertising	$ 10,050	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 4,717		
Total Dues	$ 4,717	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
DANBURY HOSPITAL FOUNDATION	$ 1,000		
ST JOESPH CHURCH	$ 200		
Total Contributions	$ 1,200	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
GAIN/LOSS ON DISPOSED EQUIPMENT	$ 9		
COMPUTER SERVICES AND EXPENSE	$ 19,547		
SMALL EQUIPMENT ADMINISTRATION	$ 2,007		
OFFICE EXPENSE - INTERNET	$ 9,025		
OFFICE EXPENSE - SOFTWARE	$ 40,612		
BANK SERVICE CHARGES	$ 3,030		
RESIDENT RELATED MISC EXP	$ 181		
PROFESSIONAL DUES/LICENSE/FEES	$ 2,937		
MISCELLANEOUS EXPENSE	$ (32)		
SHORT-TERM LEASES	$ 3,769		
PAYROLL SERVICE	$ 14,535		
OTHER COVID -19 RELATED EXPENSES	$ 6,051		
Total Other Administrative and General	$ 101,670	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABI	461-C	9/30/2020	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 #

*** 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.**

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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
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2020	18	37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	157,584	157,584		
2. Non-Food Supplies	$	20,923	20,923		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____ EQUIPMENT RENTAL-DIETARY DIETARY EQUIPMENT REPAIR	$	2,266	2,266		
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	180,772	180,772		

2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F. Resident Meals:	Total no. of meals served per day:*	170	170		

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

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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
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2020	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. $	8,756	8,756		
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. $	11,098	11,098		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*) EQUIPMENT RENTAL AND REPAIR	$	10,462	10,462		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	30,316	30,316		

3E.	Laundry Questionnaire			
F.	Is cost of employee laundry included in 3D?	O Yes	⊙ No	If yes, specify cost.
G.	Did you receive revenue from employees?	O 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?	O Yes	⊙ No	If yes, specify cost.
J.	Did you receive revenue from these people?	O 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.

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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
FILOSA FOR NURSING AND REHABILITA	461-C	9/30/2020	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel		39,605	39,605		
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	32,007	32,007		
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*) COVID RELATED CLEANING SUPPLIES		$	6,886	6,886		
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	38,893	38,893		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from OMNICARE		$	45,234	45,234		
b. Medicine Cabinet Drugs		$	1,139	1,139		
c. Medical and Therapeutic Supplies		$	128,013	128,013		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	4,917	4,917		
f. X-rays and Related Radiological Procedures***		$				
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***		$	4,370	4,370		
i. Recreation		$	2,714	2,714		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	48,258	48,258		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	234,645	234,645		

* 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 EXPENSE	$ 14,847		
TECH. COMPONENT PART A CHARGES	$ 4,967		
MED/SURG SUPPLY PART A	$ (135)		
COVID PPE RELATED EXPENSE	$ 28,579		
Total Other Resident Care	$ 48,258	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2020	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
ORESTES J. ARCUNI	WEST REDDING, CT 06896	○	⊙		EVALUATIONS AND SERVICES	10,800			13	B8E
GRACE AHERN, R.D.	ROAD, DANBURY, CT 06811	○	⊙		DIETICIAN - DIETARY NEEDS AND REPORTS	13,005			13	B1
SYMBRIA REHAB	PARKWAY, WARRENVILLE, IL	○	⊙		EVALUATIONS AND TREATMENT	345,506			13	VAR
SERAFIMA M. GLOUZGAL	RIDGEFIELD, CT 06877	○	⊙		MEDICAL DIRECTOR	27,600			13	B8A
CELTIC CONSULTING LLC	TORRINGTON, CT 06790	○	⊙		MDS COMPILANCE	2,058			16	M11
CLIFTON LARSON ALLEN LLP	DRIVE, STE 310, QUINCY MA 02169	○	⊙		ACCOUNTING SERVICES	10,300			15	1D
LAURIE A FIGLIOLA RDN	ROAD, WESTON, CT 06883	○	⊙		DIETICIAN - DIETARY NEEDS AND REPORTS	10,643			13	B1
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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).

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILIT	461-C	9/30/2020	22	37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	76,842	76,842		
b. Heat	$	40,439	40,439		
c. Light & Power	$	58,035	58,035		
d. Water	$	27,043	27,043		
e. Equipment Lease (*Provide detail on page 6*)	$	8,161	8,161		
f. Other (*itemize*)	$	39,625	39,625		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	250,145	250,145		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	120,877	120,877		
c. Non-Movable Equipment	$	7,028	7,028		
d. Movable Equipment	$	44,059	44,059		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	171,964	171,964		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	49,830	49,830		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	49,830	49,830		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	617,275	617,275		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	56,428	56,428		
c. Personal property taxes	$	9,094	9,094		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	904,591	904,591		

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

FILOSA FOR NURSING AND REHABILITATION
COST YEAR 2020
LICENSE NO 461-C

ATTACHMENT TO PAGE 22 OF 37 - LINE 9 RENTAL PAYMENTS ON LEASED REAL PROPERTY LESS DEPRECIATION CLAIMED

	TOTAL	CCNH	RHNS
RENTAL PAYMENT OF FACILTY BUILDING	$ 780,000	$ 780,000	$ -
LESS: DEPRECIATION ON PROPERTY FROM RELATED PARTY (Does not include depreciation on addition)	(120,877)	(120,877)	-
	$ 659,123	$ 659,123	-
OTHER RENTAL PAYMENTS			
PARKING LOT RENTAL - SPACE PANTS, LLC	8,100	8,100	
RENT OF OFF SITE STORAGE - SPACE PANTS, LLC	6,480	6,480	-
	$ 673,703	$ 673,703	$ -

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
REFUSE REMOVAL	$ 25,982		
EXTERMINATING	$ 3,402		
OUTSIDE SERVICE-GROUNDS	$ 4,187		
REPAIRS/MAINTENANCE-GROUNDS	$ 2,341		
INTERIOR DECOR MAINT/SUPPLY	$ 1,732		
MAINT SUPPLIES-SMALL EQUIP	$ 1,501		
DIESEL FUEL FOR GENERATOR	$ 479		
Total Other Repairs and Maintenance	$ 39,625	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
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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	4,835,483		4,835,483	3,165,473	SL	40	120,877	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								120,877
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	127,283		127,283	8,406	SL	VARIOUS	7,028	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								7,028

	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. 2015 FORD F250 PICKUP	Yes		10	2015	44,463		44,463	44,463				
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					612,224		612,224	380,761	SL	VARIOUS	42,286	
b. Disposals (attach schedule)					(9,550)			9,541			100	
c. Acquired during this report period (attach schedule)					16,370						1,673	
D-3. Subtotal												44,059
E. ***Total Depreciation***												171,964

Schedule of Land Improvements Acquired during this report peri

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 peri

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:					
2/1/2020	HP DESKTOP COMPUTERS (16)	$ 8,933	5	$ 1,191	
1/1/2020	ICE CUBER	$ 2,134	7	$ 229	
2/1/2020	OFFICE FURNITURE	$ 2,234	10	74	
3/1/2020	OFFICE FURNITURE	$ 3,069	10	179	
Total additions for Movable Equipmen		$ 16,370		$ 1,673	*
Deletions:					
	SEE ATTACHED	$ (9,550)	VARIOUS	$ 100	
Total deletions for Movable Equipmen		$ (9,550)		$ 100	**

***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:					
Total additions for Leasehold Improvemer		$ -		$ -	*
Deletions:					
Total deletions for Leasehold Improvemer		$ -		$ -	**

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

ATTACHMENT TO PAGE 23 OF 37 GENERAL INFORMATION AND QUESTIONAIRE
PAGE 23. D. 2.B DISPOSALS

DispDate	9/30/2020

Category	Description	Years	Quarters	Acquired	Sum of DispAmount	Sum of YTD	Sum of TotalToDate
office & computer equip.	HP 6445B-90W	2011	Qtr1	Mar	149.00	-	149.00
	HP Photosmart C310A Color Prtr	2011	Qtr1	Mar	165.00	-	165.00
	HP Computers(2)	2012	Qtr2	Apr	1,330.00	-	1,330.00
	PC-HP Desktop Computer	2012	Qtr2	Apr	659.00	-	659.00
	Exchange Server Upgrade	2013	Qtr2	Apr	2,344.00	-	2,344.00
	HP Laserjet Pro 400	2013	Qtr1	Feb	300.00	-	300.00
	Deskpro 400 G1 Desktop (2)	2014	Qtr4	Oct	1,208.85	-	1,208.85
	HP business Desktop ProDesk 400 G1	2014	Qtr3	Aug	610.98	-	610.98
	HP ProDesk 400 G1 Desktop	2014	Qtr3	Sep	608.85	-	608.85
	Proliant Server, license, hard drive	2014	Qtr1	Mar	1,673.95	-	1,673.95
	4 Dell 20" IPS Monitors	2015	Qtr4	Dec	500.00	99.96	483.14
Grand Total					**9,549.63**	**99.96**	**9,532.77**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
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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.									
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			VARIOUS	855,738	522,509	SL	VARI	49,830	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									49,830
D. ***Total Amortization***									49,830

* 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
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11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	1995 MAJOR RENOVATION
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	1947
5. Total Licensed Bed Capacity	64
6. Square Footage	39,605
7. Acquisition Cost	
a. Land	398,123
b. Building	4,835,483

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	12/22/16			
c. Interest Rate for the Cost Year	3.31%			
d. Term of Mortgage (number of years)	10			
e. Amount of Principal Borrowed	2,476,000			
f. Principal balance outstanding as of 9/30/2020	1,462,764			
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.

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

Name of Facility	License No.	Report for Year Ended			Page of
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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)

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

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND RI	461-C	9/30/2020	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*)			$	3,502	3,502		
A. Item SEE ATTACHED	Rate	Amount					
Lender							
Address of Lender							
B. Item	Rate	Amount					
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)			$	3,502	3,502		
12. D. Other Interest Expense (*Specify*) SEE ATTACHED			$	2,847	2,847		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)			$	6,349	6,349		
14. Insurance							
a. Insurance on Property (buildings only)			$	2,974	2,974		
b. Insurance on Automobiles			$	3,003	3,003		
c. Insurance other than Property (as specified above)							
1. Umbrella (*Blanket Coverage*)			$	8,398	8,398		
2. Fire and Extended Coverage			$	31,378	31,378		
3. Other (*Specify*) DOL AND CYBER LIABILITY			$	10,256	10,256		
14d. ***Total Insurance Expenditures (14a + b + c)***			$	56,008	56,008		
15. ***Total All Expenditures (A-13 thru C-14)***			$	7,369,368	7,369,368		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2020	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.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1C	Bad Debts $	24,000	24,000		
10.	15	1D	Accounting $	250	250		
10a.			Legal $	10,216	10,216		
11.			Telephone $				
12.	15	1H2	Cellular Telephone $	671	671		
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.	16	L3	Gifts, flowers and coffee shops $	3,025	3,025		
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	M3	Unallowable Advertising * $	10,050	10,050		
19.	15	K1	Income Tax / Corporate Business Tax $	94,648	94,648		
20.	16	10	Fund Raising / Contributions $	1,200	1,200		
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	3,187	3,187		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $				
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) $	147,247	147,247		

* 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.

FILOSA FOR NURSING AND REHABILITATION
COST YEAR 2020
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ATTACHMENT TO PAGE 27 OF 37 GENERAL INFORMATION AND QUESTIONAIRE

INSURANCE PAID

FIDUCIARY	$	-	
DIRECTORS AND OFFICER		8,352	DISALLOW
PROFESSIONAL LIABILITY		-	
CYBER LIABILITY		1,904	
PRIOR YEAR INSURANCE RELATED ADJ		-	DISALLOW
TOTAL		**$ 10,256**	**14.C.3**
Automobile- Santa Fe		820	DISALLOW

INTEREST EXPENSE

ITEMS	AMOUNT	RATE	LENDER	ADDRESS	ORIGINAL AMT
ENERGY EFFICIENT LIGHTING UPGRADE	907	4.75%	EVERSOURCE	PO BOX 650032, DALLAS, TX, 75265-0032	$ 33,018
RENOVATION IMPROVEMENTS	1,544	4.5%	UNION SAVINGS BANK	225 MAIN STREET, DANBURY, CT 06810	$ 160,000
PARKING LOT IMPROVEMENTS	253	4%			$ 40,000
TELEPHONE SYSTEM	797	5%	CAROUSEL INDUSTRIES	PO BOX 790488, ST LOUIS, MO 63179	$ 53,441
	$ 3,502	**12C2B**			
LINE OF CREDIT	$ 2,030	4.75%	UNION SAVINGS BANK	225 MAIN STREET, DANBURY, CT 06810	
FINANCIAL CHARGES	817	DISALLOW			
	$ 2,847	**12.C.2.D**			

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	M13	GAIN/LOSS ON DISPOSED EQUIPMENT	$ 9		
16	M13	BANK SERVICE CHARGES	$ 3,030		
16	M13	MISCELLANEOUS EXPENSE	$ (32)		
16	M13	RESIDENT RELATED MISC EXP	$ 181		
Total Other A&G Adjustments			$ 3,187	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
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Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	147,247	147,247		
Page 20 - Resident Care Supplies***							
27.	20	5A2	Prescription Drugs $	45,234	45,234		
28.			Ambulance/Limousine $				
29.			X-rays, etc $				
30.	20	5H	Laboratory $	4,370	4,370		
31.	20	5C	Medical Supplies $	4,221	4,221		
32.	20	5E2	Oxygen (non emergency) $	4,917	4,917		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	4,977	4,977		
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.	27	14C3	Property Insurance $	9,172	9,172		
Other - Miscellaneous							
42.			Other - Indirect $				
43.			Interest Income on Account Rec. $				
44.			Other - Miscellaneous Administrative $	817	817		
45.			Management Fees Direct $				
46.			Management Fees Indirect $				
47.			Other - Direct $				
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
49. ***Total Amount of Decrease (Items 1 - 48)***			$	220,954	220,954		

*** 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.

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5L	TECH. COMPONENT PART A CHARGES	$ 4,967		
20	5L	MED/SURG SUPPLY PART A	$ (135)		
20	5B	E-BOX DRUGS	$ 145		
Total Other Ancillary Costs			$ 4,977	$ -	$ -

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			$ -	$ -	$ -

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)
27	D	FINANCIAL CHARGES	$ 817		
Total Other Adjustments			$ 817	$ -	$ -

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			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
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Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents *(CT only)*	$	6,975,970	6,975,970		
b. Medicaid Room and Board Contractual Allowance **	$	(3,187,895)	(3,187,895)		
2. a. Medicaid *(All other states)*	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	843,460	843,460		
b. Medicare Room and Board Contractual Allowance **	$	309,786	309,786		
4. a. Private-Pay Residents and Other	$	2,297,110	2,297,110		
b. Private-Pay Room and Board Contractual Allowance **	$	(8,456)	(8,456)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	95,323	95,323		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(92,685)	(92,685)		
c. Prescription Drugs - Non-Medicare	$				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$				
2. a. Medical Supplies - Medicare	$	1,849	1,849		
b. Medical Supplies - Medicare Contractual Allowance **	$	(1,849)	(1,849)		
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	254,811	254,811		
b. Physical Therapy - Medicare Contractual Allowance **	$	(172,480)	(172,480)		
c. Physical Therapy - Non-Medicare	$				
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	45,420	45,420		
b. Speech Therapy - Medicare Contractual Allowance **	$	(23,600)	(23,600)		
c. Speech Therapy - Non-Medicare	$	645	645		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(645)	(645)		
5. a. Occupational Therapy - Medicare	$	305,265	305,265		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(205,719)	(205,719)		
c. Occupational Therapy - Non-Medicare	$				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	(3,659)	(3,659)		
b. Other *(Specify)* - Non-Medicare	$	(8,910)	(8,910)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	7,423,740	7,423,740		
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)*	$	424	424		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	427,827	427,827		
V. Total Other Revenue (1 thru 8)	$	428,251	428,251		
VI. Total All Revenue (III +V)	$	7,851,991	7,851,991		

* *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)
	PRIOR YEAR ADJUSTMENTS - MEDICARE A	$ (2,355)		
	PRIOR YEAR ADJUSTMENTS - MEDICARE B	$ 1,232		
	SEQUESTER REDUCTION MEDICARE B	$ (2,536)		
Total Other Resident Revenue - Medicare		$ (3,659)	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	PRIOR YEAR ADJUSTMENTS - PRIVATE	$ (5,290)		
	PRIOR YEAR ADJUSTMENTS - MEDICIAD	$ (5,195)		
	NON EMERGENCY FACILITY VAN TRANSPORT	$ 1,575		
Total Other Resident Revenue		$ (8,910)	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30/1A	UNION SAVINGS BANK	1,472,227	$ 424		
Total Interest Income			$ 424	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
15/1G	FEE FOR COPIES	$ 119		
VARIOUS	MEDICAID RATE RELIEF FUNDS	$ 126,630		
VARIOUS	HHH CARE ACT	$ 300,527		
15/1A5	CARES ACT SICKPAY TAX CREDIT	$ 551		
Total Other Revenue		$ 427,827	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHAB	461-C	9/30/2020	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 1,477,061
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 628,244
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 1,987
4 Inventories				$
5. Prepaid Expenses				$ 147,747
a. INSURANCE		137,136		
b.				
c.				
d. See Schedule		10,611		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,255,039
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	855,738		$ 283,399
	Accum. Depreciation	572,339	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	619,044		$ 194,224
	Accum. Depreciation	424,820	Net	
7. Motor Vehicles	*Historical Cost	44,463		$
	Accum. Depreciation	44,463	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 477,623

* 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	
		MAINTENANCE	$ 9,066
		HEALTH	$ (1,691)
		COMPUTER	$ 589
		REFUSE	$ 1,049
		COMPUTER SOFTWARE	$ 1,597
Total Prepaid Expenses			$ 10,611

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

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

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
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)			$ -

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHAB	461-C	9/30/2020	32	37

Account				Amount
		Total Brought Forward:	$	2,732,661
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			$	
2. Land Improvements	*Historical Cost			
	Accum. Depreciation	Net	$	
3. Buildings	*Historical Cost	4,835,483		
	Accum. Depreciation	3,286,350 Net	$	1,549,133
4. Non-Movable Equipment	*Historical Cost	127,283		
	Accum. Depreciation	15,434 Net	$	111,849
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)			$	1,660,982
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 (*itemize*)			$	
6. Loans to Owners or Related Parties (*itemize*)			$	
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)			$	59,001
BED LICENSES		48,001		
DEFERRED TAXES		11,000		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)			$	59,001
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$	4,452,645

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILIT	461-C	9/30/2020	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 258,727
2. Notes Payable (*itemize*)					$ 852,500
SBA - PAYROLL PROTECTION PROGRAM			852,500		
See Schedule					
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$ 15,851
Name of Lender	Purpose		Amount	Date Due	
EVERSOURCE	ENERGY EFFICIEN(		7,704	08/07/22	
CAROUSEL INDUSTRIE	TELPHONE SYSTEN		8,147	02/02/22	
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)					$ 2,382
5. Accrued Payroll (*Owners and/or Stockholders only*)					$ 180,699
6. Accrued Payroll Taxes Payable					$ 13,887
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*					$ 55,334
12. Other Current Liabilities (*itemize*)					$ 571,671
MEDICARE ADVANCE BILLING		248,766			
HHS CARES ACT		301,612			
ACCRUED EXPENSES		21,293			
See Schedule					
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 1,951,051

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

(Carry Total forward to next page)

FILOSA FOR NURSING AND REHABILITATION
COST YEAR 2020
LICENSE NO 461-C

ATTACHMENT TO PAGE 33,34 OF 37 GENERAL INFORMATION AND QUESTIONAIRE
PAGE 33.A.3
PAGE 34.B.1 **LOANS PAYABLE FOR EQUIPMENT**

			PAGE 33.A.3	PAGE 34.B.1	TOTAL
NAME OF LENDER	EVERSOURCE				
PURPOSE	ENERGY EFFICIENCY LIGHTING				
AMOUNT	$	30,018	$ 7,704	$ 7,390	$ 15,094
DATE DUE	8/7/2022				
NAME OF LENDER	CAROUSEL INDUSTRIES				
PURPOSE	TELPHONE SYSTEM				
AMOUNT	$	35,627	$ 8,147	$ 3,511	$ 11,658
DATE DUE	2/2/2022				
			$ -	$ -	$ -
		Total	**$ 15,851**	**$ 10,901**	**$ 26,752**

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILI	461-C	9/30/2020	34	37

Account	Amount
Total Brought Forward:	1,951,051
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$ 10,901

Name of Lender	Purpose	Amount	Date Due
EVERSOURCE	ENERGY EFFICIENCY LIGHTING	7,390	8/7/22
CAROUSEL INDUSTRIES	TELPHONE SYSTEM	3,511	2/2/22

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$ 81,624

Name and Address of Lender	Amount	Loan Date
HANCOCK HALL, 31 STAPLES ST, DANBURY, CT	81,624	

4. Other Long-Term Liabilities (*itemize*)	$
See Schedule	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 92,525
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 2,043,576

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHA	461-C	9/30/2020	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	$ 1,674,964
	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	$ 1,674,964
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$ 90,310
	3. Paid-in Surplus	$ 183,510
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (22,339)
	6. Gain or Loss for Period 10/1/2019 thru 9/30/2020	$ 482,623
	7. Total Net Worth	$ 734,104
C.	***Total Reserves and Net Worth***	$ 2,409,068
D.	***Total Liabilities, Reserves, and Net Worth***	$ 4,452,644

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHAB	461-C	9/30/2020	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2019			$ 251,481
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 7,851,991
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 7,369,368
D.	Net Income or Deficit			$ 482,623
E.	Balance			$ 734,104
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
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***	09/30/20		$ 734,104

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND	461-C	9/30/2020	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. 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
	CFO	2/15/21

Printed Name of Preparer

BENJAMIN CHIANESE, CPA

Address	Phone Number
31 STAPLES STREET	

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
BENJAMIN CHIANESE, CPA	203-794-9466

Contact Email Address

BCHIANESE@FILOSA.COM