

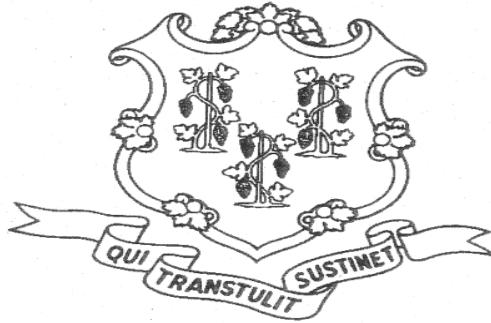
February 12, 2021

Ms. Nicole Godburn
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105
Attention: Office of Reimbursement and CON

Dear Ms. Godburn:

Enclosed please find the 2020 Medicaid Cost Report for New Milford Rehabilitation, LLC. In preparing this cost report, we did not perform any disallowances for dues expense in excess of the limits for each prescribed by your department. We also did not perform any disallowances related to physical therapy and speech therapy, which were paid for by entities other than the Medicaid Program. We did not disallow bad debts as it is netted against Private Pay Revenue. Page 23 only includes assets which were acquired by New Milford Rehabilitation subsequent to the purchase of the facility. The original purchase of building and equipment is recorded on the books of the management company at acquisition values. As this is a for-profit facility, building and non-moveable equipment value for fair rental purposes should be maintained at the prior owner basis which is recorded in the rate system for the facility. Moveable equipment assets which were acquired have been maintained for this filing at the basis of the prior owner and depreciation expense has been added to page 29 for these assets. Further, we did not disallow any depreciation or interest expense in excess of amounts previously approved via Certificate of Need or related to any prior state desk review or field audits. We believe that these disallowances are performed by the software used by your department in the preparation of the facility's rate computation report, and we do not want to create an inadvertent duplication of disallowance by calculating these adjustments. We believe this preparation methodology is in compliance with any rules and regulations of your department and the federal government.

State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2020

Name of Facility (as licensed) New Milford Rehabilitation, LLC	
Address (No. & Street, City, State, Zip Code) 30 Park Lane East, New Milford, CT 06776	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020

License Numbers:	CCNH 2207C	RHNS	(Specify)	Medicare Provider 07-5416
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Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
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For Department Use Only

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

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General Information

Name of Facility (as licensed) New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2020	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for New Milford Rehabilitation, LLC [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
Printed Name (Administrator) David Segal		Printed Name (Owner) Moshe Bernstein	
Subscribed and Sworn to before me:	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public			

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility New Milford Rehabilitation, LLC	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 30 Park Lane East, New Milford, CT 06776				
Report Prepared By CliftonLarsonAllen LLP	Phone Number 860-561-4000	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.

General Information and Questionnaire

Type of Facility - Organization Structure

General Information and Questionnaire

Partners/Members

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2020	Page of 3 37
Legal Name of Partnership/LLC		Business Address	State(s) and/or Town(s) in Which Registered
New Milford Rehabilitation, LLC		30 Park Lane East, New Milford, CT 06776	Connecticut
Name of Partners/Members	Business Address	Title	% Owned
YMW CT, LLC	1165 King Street, Greenwich, CT 06831	Owner	7.06%
SJJJ, LLC	1165 King Street, Greenwich, CT 06831	Owner	7.06%
GW Holdings, LLC	1165 King Street, Greenwich, CT 06831	Owner	54.11%
IK Greenwich, LLC	1165 King Street, Greenwich, CT 06831	Owner	7.06%
WCTHC, LLC	1165 King Street, Greenwich, CT 06831	Owner	24.71%

General Information and Questionnaire
Corporate Owners

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2020	Page of 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	
N/A			
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
N/A			
Names of Stockholders Owning at Least 10% of Shares			
N/A			

General Information and Questionnaire
Individual Proprietorship

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2020	Page of 3B 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

N/A

General Information and Questionnaire

Related Parties*

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2020			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input checked="" type="radio"/> Yes <input type="radio"/> No	If "Yes," provide the Name/Address and complete the information on Page 11 of the report.			
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?				<input checked="" type="radio"/> Yes <input type="radio"/> No	If "Yes," provide the following information:			
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Moshe Bernstein	1165 King Street, Greenwich, CT 06831	<input type="radio"/>	<input checked="" type="radio"/>		Management Services	16 m12	65,000	65,000
Mordi Blass	1165 King Street, Greenwich, CT 06831	<input type="radio"/>	<input checked="" type="radio"/>		Management Services	16 m12	65,000	65,000
Sparkle	1165 King Street, Greenwich, CT 06831	<input checked="" type="radio"/>	<input type="radio"/>	52%	Housekeeping Services	20 4b	302,872	295,756
Sparkle	1165 King Street, Greenwich, CT 06831	<input checked="" type="radio"/>	<input type="radio"/>	52%	Laundry Services and Equipment	19 3b and 3d	92,940	90,757
Skilled Marketing Solutions	1165 King Street, Greenwich, CT 06831	<input checked="" type="radio"/>	<input type="radio"/>	98%	Website Services	16 line m3	1,188	1,188
NMHC Realty, LLC	1165 King Street, Greenwich, CT 06831	<input type="radio"/>	<input checked="" type="radio"/>		Rental Expense	22 Line 9	1,226,975	1,226,975
NMHC Realty, LLC	1165 King Street, Greenwich, CT 06831	<input type="radio"/>	<input checked="" type="radio"/>		Property Insurance	27 Line 14a	25,026	25,026
NMHC Realty, LLC	1165 King Street, Greenwich, CT 06831	<input type="radio"/>	<input checked="" type="radio"/>		Real Estate Taxes	22 Line 10b	127,999	127,999
		<input type="radio"/>	<input checked="" type="radio"/>					

* Use additional sheets if necessary.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2020	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

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 9/30/2020			Page 6 of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
TIAA Copier, 245 Park Avenue New York, NY, 10167	<input type="radio"/>	<input checked="" type="radio"/>	Copier	11/09/18	63 Months	3,612	3,612
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
Is a Mileage Log Book Maintained for All Leased Vehicles ?		<input type="radio"/> Yes		<input checked="" type="radio"/> No		Total ***	3,612

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

** Attach copies of newly acquired leases.

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

General Information and Questionnaire

Accounting Basis

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2020	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm 1 See Attached 2 3 4	Address (No. & Street, City, State, Zip Code)
--	---

Services Provided by This Firm (*describe fully*)

1 See Attached	\$ 33,707
2	\$
3	\$
4	\$
	Charge for Services Provided \$ 33,707

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

Yes No |Page 15 line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney 1 See Attached 2 3 4 5	Telephone Number
--	------------------

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

1 2 3 4 5	
-----------------------	--

Services Provided by This Firm (*describe fully*)

1 See Attached	\$ 26,801
2	\$
3	\$
4	\$
5	\$
	Charge for Services Provided \$ 26,801

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

Yes No |Page 15 Line 1e

State of Connecticut

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CSP-7 Rev. 9/2002

General Information and Questionnaire
Accounting Basis

Name of Facility New Milford Rehabilitation	License No. 2207C	Report for Year Ended 09/30/2020	Page 7a	of 37
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Vendor	Description	Amount
CliftonLarsonAllen LLP	Medicare and Medicaid cost report preparation	12,340
Bonadio & Co LLP	401k audit	6,367
SY Consultant	Consulting	<u>15,000</u>
		<u><u>33,707</u></u>

State of Connecticut

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CSP-7 Rev. 9/2002

General Information and Questionnaire
Accounting Basis

Name of Facility New Milford Rehabilitation	License No. 2207C	Report for Year Ended 9/30/2020	Page 7b	of 37
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Ref	Description	Amount	Disallowed
	Goldman, Gruder & Woods, LLC Collections & General Legal Matters	\$ 17,018	16,238
	Robinson and Cole LLP General Legal Matters	9,783	
			<u>\$ 26,801</u> <u>\$ 16,238</u>

Schedule of Resident Statistics

Name of Facility New Milford Rehabilitation, LLC			License No. 2207C				Report for Year Ended 9/30/2020				Page 8	of 37
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity					148	148						
A. On last day of PREVIOUS report period	148	148										
B. On last day of THIS report period	148	148							148	148		
2. Number of Residents					133	133						
A. As of midnight of PREVIOUS report period	133	133										
B. As of midnight of THIS report period	113	113							113	113		
3. Total Number of Days Care Provided During Period					4,279	4,279						
A. Medicare	5,774	5,774							1,495	1,495		
B. Medicaid (Conn.)	27,412	27,412			20,943	20,943			6,469	6,469		
C. Medicaid (other states)												
D. Private Pay	9,618	9,618			7,543	7,543			2,075	2,075		
E. State SSI for RCH												
F. Other (Specify) VA	1,979	1,979			1,407	1,407			572	572		
G. Total Care Days During Period (3A thru F)	44,783	44,783			34,172	34,172			10,611	10,611		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days	95	95			63	63			32	32		
5. Total Resident Days (3G + 4A + 4B)	44,878	44,878			34,235	34,235			10,643	10,643		

Schedule of Resident Statistics (Cont'd)

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2020	Page 9	of 37
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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			CCNH	RHNS	(Specify)		
				(1)	(2)	(3)	(1)	(2)	(3)					

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

1st change	Change in Resident Days			CCNH	RHNS	(Specify)
	CCNH	RHNS	(Specify)	CCNH	RHNS	(Specify)
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	14	67		32				
Per Diem Rate								
a. One bed rm.	N/A	N/A		N/A				
b. Two bed rms.	PPS	234.32		450.00				
c. Three or more bed rms.	N/A	N/A		N/A				

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B		TOTAL	CCNH	RHNS	(Specify)
		3,792	3,792		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other		19,658	19,658		
D. Total Physical Therapy Treatments		23,450	23,450		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B		396	396		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other		1,588	1,588		
D. Total Speech Therapy Treatments		1,984	1,984		

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B		1,269	1,269		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other		12,246	12,246		
D. Total Occupational Therapy Treatments		13,515	13,515		

Report of Expenditures - Salaries & Wages

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2020	Page 10	of 37	
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No					
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	153,757	2,080			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	229,194	9,115			
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor	68,758	2,132			
c. Dietary Workers	448,390	25,380			
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers					
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	60,922	2,080			
b. Other Maintenance Workers	46,959	2,832			
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers					
9. Barber and Beautician Services					
10. Protective Services					
11. Accounting Services					
a. Head Accountant					
b. Other Accountants					
12. Professional Care of Residents					
a. Directors and Assistant Director of Nurses	251,888	4,160			
b. RN					
1. Direct Care	1,029,356	24,606			
2. Administrative**	304,943	4,589			
c. LPN					
1. Direct Care	1,580,724	52,774			
2. Administrative**	69,995	2,071			
d. Aides and Attendants	2,253,776	123,493			
e. Physical Therapists					
f. Speech Therapists					
g. Occupational Therapists					
h. Recreation Workers	186,411	9,445			
i. Physicians					
1. Medical Director					
2. Utilization Review					
3. Resident Care***					
j. Dentists					
k. Pharmacists					
l. Podiatrists					
m. Social Workers/Case Management	272,818	9,055			
n. Marketing					
o. Other (Specify)					
See Attached Schedule	179,702	8,049			
<i>A-13. Total Salary Expenditures</i>	7,137,593	281,861			

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

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

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

Schedule of Other Salaries and Wages (Page 10)

Schedule of Other Fees (Page 13)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-11 Rev. 10/2005

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

Name of Facility New Milford Rehabilitation, LLC			License No. 2207C		Report for Year Ended 9/30/2020			Page 11	of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

* 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
New Milford Rehabilitation, LLC				2207C		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***										
David Segal	153,757			Same as employees	Administrator	2,080	A2			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended		Page	of
	2207C	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	22,061	475			
2. Dentist	6,121	Disallowed			
3. Pharmacist	16,507	Disallowed			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	387,335	5,314			
b. Other					
6. Social Worker					
7. Recreation Worker	3,325	28			
8. Physicians					
a. Medical Director (entire facility)	42,136	275			
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**	12,000	Disallowed			
d. Administrative Services facility					
1. Infection Control Committee (Quarterly meetings)					
2. Pharmaceutical Committee (Quarterly meetings)					
3. Staff Development Committee (Once annually)					
e. Other (Specify) Medical Staff Meetings	85	1			
9. Speech Therapist					
a. Resident Care	92,731	862			
b. Other					
10. Occupational Therapist					
a. Resident Care	271,576	3,716			
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	99,619	686			
B-13 Total Fees Paid in Lieu of Salaries	953,496	11,357			

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

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

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

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

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

Report of Expenditures

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

Name of Facility New Milford Rehabilitation	License No. 2207C	Report for Year Ended 9/30/2020	Page 14a	of 37
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G/L Account #	Direct Care Consultant	Company/Individual Name	Full Explanation of Services	Total Fee Paid*	Total Hours Worked
69155.000	Dietician	Laura Koski	Dietary Consultation	22,061	475
87110.000	Dentist	CT Dental Group	Dentistry	6,121	Disallowed
85050.000	Pharmacist	Omnicare of Connecticut	Pharmacy	16,507	Disallowed
80950.000 80980.000	Physical Therapy	Preferred Therapy Solutions	Physical Therapy	387,335	5,314
61660.000	Recreation Worker	Various - see Pg. 14b	Recreation	3,325	28
87100.000	Medical Director	Ken Marici	Medical Director	42,136	275
87100.000	Rehab Director	John Mullen	Rehab Director	12,000	Disallowed
87105.000	Utilization Review	Burton R Rubin MD	Medical Staff Meeting	85	1
82950.000 82980.000	Speech Therapist	Preferred Therapy Solutions	Speech Therapy	92,731	862
81950.000 81980.000	Occupational Therapist:	Preferred Therapy Solutions	Occupation Therapy	271,576	3,716
67850.000	Nursing Admin Purchased Services	Acute Care Gases Assoc. Pulmonologists Of W.CT, LLC Preferred Therapy Solutions Health Drive Podiatry Advanced Specialty Care, P.C. CT Family Orthopedics, P.C. Swallowing Diagnostics LLC Visiting Angels Brookfield Kenneth Marici, MD, PC	Oxygen supply MDs Rehab MDs MDs MDs MDs MDs MDs MDs	2,401 236 16,247 1,035 48 118 7,200 442 1,741 29,468	Disallowed Disallowed Disallowed Disallowed Disallowed Disallowed Disallowed Disallowed Disallowed -
		Teresa Skinner	MDs	70,151 70,151	686 686
				Total Fees	953,496
					11,357

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

Name of Facility New Milford Rehabilitation	License No. 2207C	Report for Year Ended 9/30/2020	Page 14b	of 37
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Activities Entertainment

Entertainment	Description	Date	Total Paid
Bill Michael	Entertainment	10/3/2019	\$125.00
Danny Russo	Entertainment	10/10/2019	\$125.00
James I. Moore	10/17/19-entertainment	10/17/2019	\$100.00
Danny Russo	Entertainment	10/31/2019	\$125.00
Don Lowe	Entertainment	10/25/2019	\$100.00
Willie Nininger, Incorporated	Entertainment	10/29/2019	\$150.00
Frank Palmer	11/7/19- Entertainment	11/7/2019	\$100.00
Robert Brophy	Entertainments	11/21/2019	\$100.00
Joel Blumert	Entertainment	11/14/2019	\$100.00
Dean Snellback	Entertainment	11/28/2019	\$100.00
Willie Nininger, Incorporated	Entertainment	11/25/2019	\$150.00
Larry Ayco Crasilli	Entertainment	12/5/2019	\$150.00
Robert Brophy	12/12/19 Entertainment	12/12/2019	\$100.00
James I. Moore	Entertainment	12/26/2019	\$100.00
Willie Nininger, Incorporated	Entertainment	12/31/2019	\$150.00
Candlewood Valley Health Center Petty Cash	Permit For Recreation Outtrip At Sen	1/16/2020	\$25.00
Danny Russo	Entertainment	1/16/2020	\$125.00
Robert Brophy	Entertainment	1/9/2020	\$100.00
Dean Snellback	Entertainment	1/23/2020	\$100.00
Willie Nininger, Incorporated	Entertainment	1/21/2020	\$150.00
James I. Moore	Entertainment	1/2/2020	\$100.00
James I. Moore	Entertainment	2/6/2020	\$100.00
Bill Michael	Entertainment	2/20/2020	\$250.00
Robert Brophy	Entertainment	2/13/2020	\$100.00
Ethel Kaufman	Entertainment	2/27/2020	\$100.00
Willie Nininger, Incorporated	Entertainment	2/25/2020	\$150.00
James I. Moore	Entertainment	3/5/2020	\$100.00
Larry Ayco Crasilli	1/30/2020 Entertainment	5/1/2020	\$150.00

Total Activities & Entertainment \$3,325.00

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2020	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 272,408	272,408		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 76,304	76,304		
4. Social Security (F.I.C.A.)	\$ 529,601	529,601		
5. Health Insurance	\$ 1,086,503	1,086,503		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 23,232	23,232		
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$			
d. Accounting and Auditing	\$ 33,707	33,707		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 26,801	26,801		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 31,456	31,456		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 31,659	31,659		
2. Cellular Phones	\$ 1,579	1,579		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$			
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$			
2. Other (<i>Specify</i>) See Attached Schedule	\$ 141,293	141,293		
3. Resident Day User Fee	\$ 763,488	763,488		
Subtotal	\$ 3,018,031	3,018,031		

* 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

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Business Taxes - Disallowed	\$ 197		
State Passthrough Entity Tax	\$ 141,096		
Total	\$ 141,293	\$ -	\$ -

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

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2020		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
<i>Subtotals Brought Forward:</i>		3,018,031	3,018,031		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$	15,660	15,660		
4. Employee Travel	\$	2,687	2,687		
5. Education Expenses Related to Seminars and Conventions	\$	10,160	10,160		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$	14,448	14,448		
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	10,081	10,081		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	35,714	35,714		
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)***	\$	840	840		
7. Postage	\$	6,129	6,129		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	10,417	10,417		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	350	350		
9. Subscriptions	\$	7,166	7,166		
10. Contributions*** See Attached Schedule	\$	2,873	2,873		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	30,846	30,846		
12. Administrative Management Services**	\$	130,000	130,000		
13. Other (<i>Specify</i>) See Attached Schedule	\$	117,797	117,797		
<i>C-14 Total Administrative & General Expenditures</i>	\$	3,413,199	3,413,199		

* 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)
Business Promotions - Disallowed	\$ 33,288		
Other Advertising - Disallowed	\$ 2,426		
Total Other Advertising	\$ 35,714	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Dues - See pg 16b	\$ 10,417		
Total Dues	\$ 10,417	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
American Cancer Society	\$ 2,355		
Tribury Rotary Club	\$ 518		
Total Contributions	\$ 2,873	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Employee Background Checks	\$ 3,722		
Data Processing Fees	\$ 25,201		
Software Maintenance	\$ 60,867		
Insurance - EPLI	\$ 11,023		
Insurance - Bond	\$ 750		
Facility Licenses	\$ 2,786		
Vending/Soda Expense - Disallowed	\$ 17		
Bank Charges	\$ 12,129		
State Assessment - Disallowed	\$ 1,180		
Miscellaneous Expense	\$ 4		
Employee Licenses	\$ 118		
Total Other Administrative and General	\$ 117,797	\$ -	\$ -

Detail of Dues and Subscriptions

Name of Facility New Milford Rehabilitation	License No. 2207C	Report for Year Ended 9/30/2020	Page 16b	of 37
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Description	Total Amount	Dues	Subscriptions	Chamber of Commerce
Allscripts Healthcare, LLC	3,950		3,950	
CAHCF Membership	700	700		
Hearst Media Services, CT, LLC	2,730		2,730	
Language Line Services	330		330	
Audible Audio Books	96		96	
Amazon Prime Annual Subscription	60		60	
Second Wind Dreams	1,995	1,995		
New Milford Chamber of Commerce - Disallowed	350			350
NaviHealth Membership	7,362	7,362		
Housatonic Business Association Membership	360	360		
	\$ 17,933	\$ 10,417	\$ 7,166	\$ 350

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2020	Page 17 37 of
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 #
Moshe Bernstein	65,000	Management Services	16 m12
Mordi Blass	65,000	Management Services	16 m12

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

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

Name of Facility	License No.	Report for Year Ended		Page of
	2207C	9/30/2020		18 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 267,021	267,021		
2. Non-Food Supplies	\$ 26,602	26,602		
3. Other (Specify) _____ Chemicals / Cleaning Supplies	\$ 10,853	10,853		
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$			
c. Other (Specify) _____ Nutritional Supplements	\$ 13,897	13,897		
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 318,373	318,373		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*				
G. Is cost of employee meals included in 2D? <input checked="" type="radio"/> Yes <input type="radio"/> No				
H. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D? <input checked="" type="radio"/> Yes <input type="radio"/> No				If yes, specify cost.
K. Is any revenue collected from these people? <input checked="" type="radio"/> Yes <input type="radio"/> No				If yes, specify amt. \$696
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				30 IV1
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2020		Page 19	of 37
Item	Total	CCNH	RHNS	(Specify)	
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	72	72		
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. \$				
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$	269,514	269,514		
c. Other (Specify) Supplies \$911 / Equipment Rental \$1,444	\$	2,355	2,355		
3D. Total Laundry Expenditures (3a + b + c)	\$	271,941	271,941		
3E. Laundry Questionnaire					
F. Is cost of employee laundry included in 3D?	<input checked="" type="radio"/> Yes	<input type="radio"/> No	If yes, specify cost.		
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
K. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3D.

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

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

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2020		Page 20	of 37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 41,619	41,619		
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)					
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel				
	Amt.	\$ 302,872	302,872		
C. Other (<i>Specify</i>)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	344,491	344,491		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	307,939	307,939		
Medicare \$222,197; Medicaid \$11,292; Managed Care \$73,892; Ever Care \$558					
b. Medicine Cabinet Drugs	\$	13,794	13,794		
c. Medical and Therapeutic Supplies	\$	105,324	105,324		
d. Ambulance/Limousine***	\$	7,941	7,941		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	3,667	3,667		
f. X-rays and Related Radiological Procedures***	\$	20,369	20,369		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	45,612	45,612		
i. Recreation	\$	1,461	1,461		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	214,898	214,898		
5M. Total Resident Care Expenditures (5a - 5j)	\$	721,005	721,005		

* 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

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

Name of Facility New Milford Rehabilitation, LLC				License No. 2207C	Report for Year Ended 9/30/2020				Page of 21 37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Sparkle	1165 King Street, Greenwich, CT 06831	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	Housekeeping	302,872			20	4b
Sparkle	1165 King Street, Greenwich, CT 06831	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	Laundry Service and Equipment	92,940			19	3b
Shamrock	Road, Monroe, CT 06468	<input type="radio"/>	<input checked="" type="radio"/>		Grounds Maintenance	22,323			22	6f
All American Waste	P.O. Box 630, East Windsor, CT 06088	<input type="radio"/>	<input checked="" type="radio"/>		Trash Removal	24,613			22	6f
Smartlink Solutions	PO Box 22598 New York NY 10087	<input type="radio"/>	<input checked="" type="radio"/>		Computer Software	11,295			16	m13
MatrixCare	Bin #32, PO Box 1414, Minneapolis, MN, 55480	<input type="radio"/>	<input checked="" type="radio"/>		Healthcare Software	48,129			16	m13
Saucier	148 North Street, Plantsville, CT 06479	<input type="radio"/>	<input checked="" type="radio"/>		HVAC	24,814			22	6a
Image First	PO Box 61323 King of Prussia PA 19406	<input type="radio"/>	<input checked="" type="radio"/>		Laundry Service	176,574			19	3b
Crown Care Services	PO Box 86, Lakewood, NJ 08701	<input type="radio"/>	<input checked="" type="radio"/>		Document Storage	15,533			22	6f
A. Santino	42 Robin Hill Lane, Hamden, CT 06518	<input type="radio"/>	<input checked="" type="radio"/>		IT Consultant	23,736			16	m11
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

* List all contracted services over \$10,000. Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2020			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	56,698	56,698			
b. Heat	\$	99,300	99,300			
c. Light & Power	\$	142,545	142,545			
d. Water	\$	64,650	64,650			
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$	3,612	3,612			
f. Other (<i>itemize</i>)	\$	130,595	130,595			
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	497,400	497,400			
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$	60,267	60,267			
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$	18,900	18,900			
*7e. Total Depreciation Costs (7a + b + c + d)	\$	79,167	79,167			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	1,226,975	1,226,975			
10. Property Taxes						
a. Real estate taxes paid by owner	\$	127,999	127,999			
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$	19,249	19,249			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	1,453,390	1,453,390			

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Trash Removal/ shredding	\$ 48,242		
Service Contracts	\$ 31,653		
Plant Supplies	\$ 20,785		
Grounds Maintenance	\$ 26,740		
Plant Purchased Services - Disallowed	\$ 200		
Plant Other	\$ 147		
A&G Equipment Rental	\$ 1,649		
Minor Decorating - Disallowed	\$ 457		
Copy Charges	\$ 537		
Charges Not Meeting Criteria for Page 6	\$ 185		
Total Other Repairs and Maintenance	\$ 130,595	\$ -	\$ -

Depreciation Schedule

Schedule of Land Improvements Acquired during this report period

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

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

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
12/31/2019	Beds	\$ 2,470	5	\$ 371
12/31/2019	Beds	\$ 2,900	5	\$ 290
3/31/2020	Computers	\$ 3,615	5	\$ 362
7/31/2020	Beds	\$ 3,590	5	\$ 179
7/31/2020	Medical Scanner	\$ 3,650	7	\$ 130
7/31/2020	Rockers	\$ 2,765	10	\$ 92
9/30/2020	Beds	\$ 2,430	5	\$ -
9/30/2020	Beds	\$ 1,523	5	\$ -
9/30/2020	Doors	\$ 3,112	7	\$ -
Total additions for Movable Equipment		\$ 26,055		\$ 1,424 *
Deletions:				
Total deletions for Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

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

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility New Milford Rehabilitation, LLC			License No. 2207C		Report for Year Ended 9/30/2020			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									

* 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 New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2020	Page 25	of 37
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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				
3. If NOT Original Owner, Date of Purchase	04/01/16			
4. Date of Initial Licensure	04/01/16			
5. Total Licensed Bed Capacity	148			
6. Square Footage	53,395			
7. Acquisition Cost				
a. Land				
b. Building				

Part B - Owner and Related Parties

1st Mortgage 2nd Mortgage 3rd Mortgage 4th Mortgage

1. Financing				
a. Type of Financing (e.g., fixed, variable)	Available upon			
b. Date Mortgage Obtained	request			
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of 9/30/2020				

Complete if Mortgage was Refinanced

During Current Cost Year

g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2020			Page 26	of 37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$			
Name of Lender	Rate					
Address of Lender						
2. Second Mortgage			\$			
Name of Lender	Rate					
Address of Lender						
3. Third Mortgage			\$			
Name of Lender	Rate					
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender	Rate					
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended			Page	of
		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)		\$				
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)		\$	2,631	2,631		
Insurance Notes						
13. Total All Interest Expense (12B7 + 12C3 + 12D)		\$	2,631	2,631		
14. Insurance						
a. Insurance on Property (buildings only)		\$	25,026	25,026		
b. Insurance on Automobiles		\$	3,408	3,408		
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)		\$	14,560	14,560		
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$	73,260	73,260		
Liability						
14d. Total Insurance Expenditures (14a + b + c)		\$	116,254	116,254		
15. Total All Expenditures (A-13 thru C-14)		\$	15,229,773	15,229,773		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of	
Item No.	Page No.	Line No.		2207C	9/30/2020	28 37	
			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	\$ 58,651	58,651		
			Page 13 - Professional Fees				
5.			Resident Care Physicians **	\$			
6.	13	b10a	Occupational Therapy	\$ 271,576	271,576		
7.			Other - See attached Schedule	\$ 64,096	64,096		
			Pages 15 & 16 - Administrative and General				
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.			Accounting	\$			
10a.			Legal	\$ 16,238	16,238		
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$ 499	499		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.	16	l6	Automobile Expense (e.g. personal use)	\$ 12,608	12,608		
18.	16	m3	Unallowable Advertising *	\$ 35,714	35,714		
19.	16	lk2	Income Tax / Corporate Business Tax	\$ 197	197		
20.	16	m10	Fund Raising / Contributions	\$ 2,873	2,873		
21.	16	m12	Unallowable Management Fees	\$ 130,000	130,000		
22.	16	m6	Barber and Beauty	\$ 840	840		
23.			Other - See attached Schedule	\$ 29,221	29,221		
			Page 18 - Dietary Expenditures				
24.	30	IV5	Meals to employees, guests and others who are not residents	\$ 696	696		
			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)			\$ 623,209	\$ 623,209			

* 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	Social Service Wages - Marketing Duties	\$ 13,641		
10	A2	Administrator over Allowable	\$ 45,010		
Total Other Salaries Adjustment			\$ 58,651	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	b12	Nursing Admin Purchased Services	\$ 29,468		
13	b2	Dentist	\$ 6,121		
13	8b	Rehab Director Resident Care	\$ 12,000		
13	b3	Pharmacist	\$ 16,507		
Total Other Fees Adjustments			\$ 64,096	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	13	Employee Relations	\$ 15,660		
20	4b	Housekeeping Purchased Services - Disallow markup on related party services	\$ 7,116		
19	3b	Laundry Purchased Services - Disallow markup on related party services	\$ 2,183		
		Benefits on disallowed Salary above	\$ 2,728		
16	m13	State Assessment	\$ 1,180		
16	m13	Miscellaneous	\$ 4		
16	8a	Chamber of Commerce Dues	\$ 350		
Total Other A&G Adjustments			\$ 29,221	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended		Page of
Item No.	Page No.	Line No.		2207C	9/30/2020	29 37
Item Description			Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 623,209	623,209	
<i>Page 20 - Resident Care Supplies***</i>						
27.	20	5a2	Prescription Drugs	\$ 307,939	307,939	
28.	20	5d	Ambulance/Limousine	\$ 7,941	7,941	
29.	20	5f	X-rays, etc	\$ 20,369	20,369	
30.	20	5h	Laboratory	\$ 45,612	45,612	
31.	20	5c	Medical Supplies	\$ 23,860	23,860	
32.	20	5e2	Oxygen (non emergency)	\$ 3,667	3,667	
33.			Occupational Therapy	\$		
34.			Other - See Attached Schedule	\$ 97,806	97,806	
<i>Page 22 - Maintenance and Property</i>						
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ (10,237)	(10,237)	
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	\$ 965	965	
<i>Page 27 - Insurance</i>						
40.			Mortgage Insurance	\$		
41.			Property Insurance	\$		
<i>Other - Miscellaneous</i>						
42.			Other - Indirect	\$		
43.			Interest Income on Account Rec.	\$		
44.			Other - Miscellaneous Administrative	\$		
45.			Management Fees Direct	\$		
46.			Management Fees Indirect	\$		
47.			Other - Direct	\$ 51,437	51,437	
<i>Not For Profit Providers Only</i>						
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$		
49.	<i>Total Amount of Decrease (Items 1 - 48)</i>		\$ 1,172,568	1,172,568		

*** 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	5j	Medical Supplies % of Nursing/Incontinent/Wound Care Supplies	\$ 53,745		
20	5j	OT Small Equipment Purchase	\$ 718		
20	5j	PT Equipment Rental	\$ 12,626		
20	5j	Specialty Mattresses	\$ 30,717		
Total Other Ancillary Costs			\$ 97,806	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	6f	Minor Decorating	\$ 457		
22	6f	Plant Purchased Services	\$ 200		
29B		Outpatient Therapy Rent Allocation	\$ 185		
29B		Outpatient Therapy Insurance Allocation	\$ 6		
29B		Outpatient Therapy A&G Allocation	\$ 65		
29B		Outpatient Therapy Indirect Allocation	\$ 52		
Total Other Property Adjustments			\$ 965	\$ -	\$ -

Schedule of Other - Indirect Adjustments

Attachment Page 29

Schedule of Other - Miscellaneous Administrative Adjustments

Schedule of Other - Direct Adjustments

Schedule of Unallowable Building Interest

Estimated Overhead on Outpatient Therapy

Square Footage on Therapy Space	1029
Total Square Footage of Facility	53395
	0.019271

Outpatient Treatments - per client questionnaire

PT	231
ST	19
OT	55
Total Outpatient Treatments	305

Total Treatments - Page 9 of Cost Report

PT	23,450
ST	1,984
OT	13,515
Total Therapy Treatments	38,949

Outpatient Treatments % 0.007830753

Outpatient Allocation of Therapy Space % 0.00015091

Expense Item:

Heat	99,300
Light & Power	142,545
Repairs & Maintenance	56,698
Other Repairs Maintenance	130,595
Sub-total	429,138
Outpatient Allocation of Therapy Space %	0.00015091
Unallowable A&G Expense	65

Housekeeping Salaries	0
Other Housekeeping Expense	344,491
Sub-Total	344,491
Outpatient Allocation of Therapy Space %	0.00015091
Unallowable Indirect Expense	52

Property & Umbrella Insurances (Excluding Auto)	39,586
Outpatient Allocation of Therapy Space %	0.00015091
Unallowable Capital Expense	6

Rent Expense	1,226,975
Outpatient Allocation of Therapy Space %	0.00015091
Unallowable Rent Expense	185

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended 9/30/2020			Page 30 37
Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 12,707,276	12,707,276			
b. Medicaid Room and Board Contractual Allowance **	\$ (6,231,489)	(6,231,489)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 2,576,478	2,576,478			
b. Medicare Room and Board Contractual Allowance **	\$ 1,304,880	1,304,880			
4. a. Private-Pay Residents and Other	\$ 5,193,235	5,193,235			
b. Private-Pay Room and Board Contractual Allowance **	\$ (596,088)	(596,088)			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 205,413	205,413			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (204,495)	(204,495)			
c. Prescription Drugs - Non-Medicare	\$ 157,471	157,471			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (131,214)	(131,214)			
2. a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$ 485	485			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (464)	(464)			
3. a. Physical Therapy - Medicare	\$ 572,625	572,625			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (503,906)	(503,906)			
c. Physical Therapy - Non-Medicare	\$ 363,726	363,726			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (291,928)	(291,928)			
4. a. Speech Therapy - Medicare	\$ 141,574	141,574			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (125,923)	(125,923)			
c. Speech Therapy - Non-Medicare	\$ 59,670	59,670			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (45,354)	(45,354)			
5. a. Occupational Therapy - Medicare	\$ 439,520	439,520			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (416,721)	(416,721)			
c. Occupational Therapy - Non-Medicare	\$ 232,085	232,085			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (200,942)	(200,942)			
6. a. Other (<i>Specify</i>) - Medicare	\$				
b. Other (<i>Specify</i>) - Non-Medicare	\$ 5,280	5,280			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 15,211,194	15,211,194			
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$ 696	696			
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$ 1,010	1,010			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ 120,893	120,893			
V. Total Other Revenue (1 thru 8)	\$ 122,599	122,599			
VI. Total All Revenue (III +V)	\$ 15,333,793	15,333,793			

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

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

Schedule of Other Resident Revenue - Medicare**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
30 / 6a	Oxygen Medicare A	\$ 213		
30 / 6a	X-Ray Medicare A	\$ 12,906		
30 / 6a	LAB Medicare A	\$ 36,773		
30 / 6a	Less: Contractual Adjustment	\$ (49,892)		
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
30 / 6b	LAB EverCare	\$ 5,794		
30 / 6b	Oxygen Managed Care	\$ 421		
30 / 6b	X-Ray Managed Care	\$ 6,560		
30 / 6b	LAB Managed Care	\$ 15,900		
30 / 6b	LAB Medicaid	\$ 194		
30 / 6b	Less: Contractual Adjustment	\$ (23,589)		
Total Other Resident Revenue		\$ 5,280	\$ -	\$ -

Interest Income**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30/ IV5	Interest Income	\$ 1,010			
Total Interest Income		\$ 1,010	\$ -	\$ -	

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 / 6b	Miscellaneous Income - Disallowed	\$ 30,711		
30 / 6b	Optum Program Revenue	\$ 90,182		
Total Other Revenue		\$ 120,893	\$ -	\$ -

G. Balance Sheet

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2020	Page 31	of 37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$ 1,336,514	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 1,649,438	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$ 2,696,795	
4. Inventories			\$	
5. Prepaid Expenses			\$ 119,570	
a. Expenses	24,697			
b. Insurance	79,482			
c. Sewer	8,615			
d. See Schedule	6,776			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$ 66,437	
Patient Funds Held in Trust	66,437			
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$ 5,868,754	
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	Accum. Depreciation	Net	\$
3. Buildings	*Historical Cost	897,583		\$ 782,117
	Accum. Depreciation	115,466	Net	
4. Leasehold Improvements	*Historical Cost	Accum. Depreciation	Net	\$
5. Non-Movable Equipment	*Historical Cost	Accum. Depreciation	Net	\$
6. Movable Equipment	*Historical Cost	133,931		\$ 69,070
	Accum. Depreciation	64,861	Net	
7. Motor Vehicles	*Historical Cost	Accum. Depreciation	Net	\$
8. Minor Equipment-Not Depreciable				\$
9. Other Fixed Assets (<i>itemize</i>)			\$ 172,528	
Construction in Progress	172,528			
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$ 1,023,715	

* 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

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

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

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2020	32	37
Account			Amount	
			Total Brought Forward:	\$ 6,892,469
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				\$
2. Land Improvements	*Historical Cost	Accum. Depreciation	Net	\$
3. Buildings	*Historical Cost	Accum. Depreciation	Net	\$
4. Non-Movable Equipment	*Historical Cost	Accum. Depreciation	Net	\$
5. Movable Equipment	*Historical Cost	Accum. Depreciation	Net	\$
6. Motor Vehicles	*Historical Cost	Accum. Depreciation	Net	\$
7. Minor Equipment-Not Depreciable				\$
C-8 Total Leasehold or Like Properties (C1 thru 7)				\$
D. Investment and Other Assets				
1. Deferred Deposits				\$
2. Escrow Deposits				\$
3. Organization Expense	*Historical Cost	Accum. Depreciation	Net	\$
4. Goodwill (Purchased Only)				\$
5. Investments Related to Resident Care (<i>itemize</i>)				\$
6. Loans to Owners or Related Parties (<i>itemize</i>)				\$
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)				\$ 12,810
Deposits	12,810			
See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)				\$ 12,810
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)				\$ 6,905,279

* 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 New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2020	Page 33	of 37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				\$ 474,726
2. Notes Payable (<i>itemize</i>)				\$ 4,884
Loans Payable - AW				4,884
See Schedule				
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$ 490,830
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$
6. Accrued Payroll Taxes Payable				\$ 6,949
7. Medicare Final Settlement Payable				\$
8. Medicare Current Financing Payable				\$
9. Mortgage Payable (<i>Current Portion</i>)				\$
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$
11. Accrued Income Taxes*				\$
12. Other Current Liabilities (<i>itemize</i>)				\$ 3,382,450
Deferred Revenue	1,374,133	Accrued Provider User Fe	185,712	
Resident Trust	66,437			
Accrued Operating Expenses	55,736			
Accrued Liabilities Other	1,700,432	See Schedule		
A-13. Total Current Liabilities (Lines A1 thru 12)				\$ 4,359,839

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2020	Page 34	of 37
Account			Amount	
Total Brought Forward:			4,359,839	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)			\$	
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable			\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)			\$	6,695
Due to NMHC Realty Co.	6,695			
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$	6,695
C. Total All Liabilities (Lines A-13 + B-5)			\$	4,366,534

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

Name of Facility	License No.	Report for Year Ended	Page	of
		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			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	2,434,725
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	
6. Gain or Loss for Period	10/1/2019	thru	9/30/2020	\$ 104,020
7. Total Net Worth			\$	2,538,745
C. Total Reserves and Net Worth				\$ 2,538,745
D. Total Liabilities, Reserves, and Net Worth				\$ 6,905,279

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
New Milford Rehabilitation, LLC	2207C	9/30/2020	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2019				\$ 2,434,725		
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 15,333,793		
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 15,229,773		
D. Net Income or Deficit				\$ 104,020		
E. Balance				\$ 2,538,745		
F. Additions						
1. Additional Capital Contributed (<i>itemize</i>)						
2. Other (<i>itemize</i>)						
F-3. Total Additions				\$		
G. Deductions						
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)				\$		
Name and Address (No., City, State, Zip)		Title	Amount			
2. Other Withdrawings (<i>Specify</i>)				\$		
Purpose		Amount				
3. Total Deductions				\$		
H. Balance at End of Period				\$ 2,538,745		

I. Preparer's/Reviewer's Certification

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2020	Page <u>37</u> of <u>37</u>
<i>Check appropriate category</i>			
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)	

Preparer/Reviewer Certification

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 2/12/2021
Printed Name of Preparer CliftonLarsonAllen LLP		
Address 29 S Main Street, West Hartford, CT		Phone Number 860-561-4000
Contacted Person Regarding Additional Information Needed Regarding This Report Jonathan Fink		Phone Number 860-561-4000
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