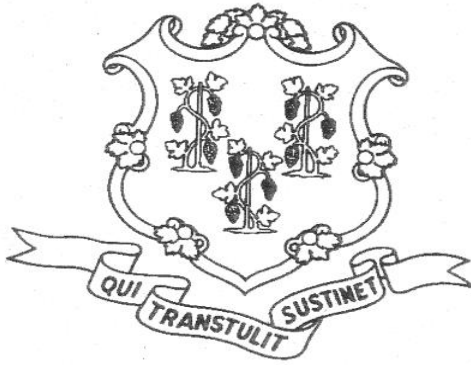


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2022

Name of Facility (as licensed) Senior Philanthropy of Milford O, LLC d/b/a West River Rehab Center	
Address (No. & Street, City, State, Zip Code) 245 Orange Ave, Milford, CT 06461	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2021	Report for Year Ending 9/30/2022

License Numbers:	CCNH 2404	RHNS	(Specify)	Medicare Provider 07-5377
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Medicaid Provider Numbers:	CCNH 20925	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

General Information

Name of Facility (as licensed) Senior Philanthropy of Milford O, LLC d/b/a West Riv	License No. 2404	Report for Year Ended 9/30/2022	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 Senior Philanthropy of Milford O, LLC d/b/a West River Rehab Center [facility name], for the cost report period beginning October 1, 2021 and ending September 30, 2022, 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.

(a) Subject to Desk Audit review

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) T. Kevin Cleary			Printed Name (Owner)		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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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 Senior Philanthropy of Milford O, LLC d/b/a West River Rehab Center		Period Covered:	From 10/1/2021	To 9/30/2022
Address of Facility 245 Orange Ave, Milford, CT 06461				
Report Prepared By Marcum LLP		Phone Number 203-781-9600	Date 2/28/2023	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-876-5123		Report for Year Ended 9/30/2022	Page 2	of 37
Name of Facility (as shown on license) Senior Philanthropy of Milford O, LLC d/b/a West River Reha		Address (No. & Street, City, State, Zip) 245 Orange Ave, Milford, CT 06461		
License Numbers:	CCNH 2404	RHNS	(Specify)	Medicare Provider No. 07-5377
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
New Governance				
Administrator				
Name of Administrator T. Kevin Cleary		Nursing Home Administrator's License No.:	1401	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name N/A		License No.:		

General Information and Questionnaire
Related Parties*

Name of Facility Senior Philanthropy of Milford O, LLC d/b/a West Riv	License No. 2404	Report for Year Ended 9/30/2022	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Oasis Healthcare Group	19999 Cedarbridge Ave, Suite 3B, Lakewood, NJ 08701	<input type="radio"/>	<input checked="" type="radio"/>		Consulting Fee	Pg 16/Line m11	190,375	190,375
Leading Edge Administrators	14 Wall St., Suite 5B, New York, NY 10005	<input type="radio"/>	<input checked="" type="radio"/>		Health Insurance	Pg 15/Ln 1a5	155,892	155,892
Intercompany Liabilities	N/A	<input type="radio"/>	<input checked="" type="radio"/>		Due To/From	Pg 34/ Ln B3	Var	
		<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"/>					

* 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 Senior Philanthropy of Milford O, LLC d/b/a W	License No. 2404	Report for Year Ended 9/30/2022	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility			License No.	Report for Year Ended			Page	of
Senior Philanthropy of Milford O, LLC d/b/a West River Rd			2404	9/30/2022			6	37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
Canon Financial Services, 14904 Collections Center Drive, Chicago IL 60693-0149	<input type="radio"/>	<input checked="" type="radio"/>	Copier	11/08/19	On-going	2,200	2,200	
	<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 ***							2,200	

* 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 Senior Philanthropy of Milford O, I	License No. 2404	Report for Year Ended 9/30/2022	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

- Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm 1 CJLC LLC 2 3 4	Address (No. & Street, City, State, Zip Code) 225 Pitkin St., East Hartford, CT 06108
--	--

Services Provided by This Firm (*describe fully*)

1 Medicaid Cost Report Preparation	\$ 6,417
2 General Accounting Services(Disallowed on Page 28)	\$ 4,825
3	\$
4	\$
	Charge for Services Provided
	\$ 11,242

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 Goldman Gruder & Woods, LLC 2 Chubb 3 CT Corporation 4 Murtha Cullina, LLP 5 Various	Telephone Number 203-899-8900 203-772-7700
--	--

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

- 1 200 Connecticut Ave, Norwalk, CT 06854
 2 PO Box 8500, Philadelphia, PA 19178-6907
 3 PO Box 4349, Carol Stream, IL 60197
 4 265 Church St, New Haven, CT 06510
 5

Services Provided by This Firm (*describe fully*)

1 Resident Lawsuits(pending), Probate/Postage Fees(\$2,324 Disallowed on Page 28)	\$ 37,477
2 Settlement(50% Disallowed on Pg 28)	\$ 8,744
3 Domestic Representation(Disallowed on Pg 28)	\$ 235
4 Retainer Fee(Disallowed on Pg 28)	\$ 918
5 Conservator Fees/General Legal Matters(Disallowed on Pg 28)	\$ 1,737
	Charge for Services Provided
	\$ 49,111

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

Annual Report of Long-Term Care Facility

Schedule of Resident Statistics

Name of Facility			License No.			Report for Year Ended				Page		of	
Senior Philanthropy of Milford O, LLC d/b/a West River Rehab Center			2404			9/30/2022				8		37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	120	120			120	120							
B. On last day of THIS report period	120	120							120	120			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	100	100			100	100							
B. As of midnight of THIS report period	109	109							109	109			
3. Total Number of Days Care Provided During Period													
A. Medicare	3,475	3,475			2,545	2,545			930	930			
B. Medicaid (Conn.)	26,263	26,263			19,511	19,511			6,752	6,752			
C. Medicaid (other states)													
D. Private Pay	3,795	3,795			2,862	2,862			933	933			
E. State SSI for RCH													
F. Other (Specify) HMO, Hospice, Insurance, VA	3,624	3,624			2,692	2,692			932	932			
G. Total Care Days During Period (3A thru F)	37,157	37,157			27,610	27,610			9,547	9,547			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days	70	70							70	70			
B. Other Bed Reserve Days													
5. Total Resident Days (3G + 4A + 4B)	37,227	37,227			27,610	27,610			9,617	9,617			

Schedule of Resident Statistics (Cont'd)

Name of Facility Senior Philanthropy of Milford O, LLC d/b/a			License No. 2404			Report for Year Ended 9/30/2022			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days								CCNH	RHNS	(Specify)			
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	14		77		18								
Per Diem Rate													
a. One bed rm.	Various		318.00		603.00								
b. Two bed rms.	Various		318.00		686.00								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								1,584	1,584				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								841	841				
2. Restorative Treatments													
C. Other								6,105	6,105				
D. Total Physical Therapy Treatments								8,530	8,530				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								731	731				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								352	352				
2. Restorative Treatments													
C. Other								2,123	2,123				
D. Total Speech Therapy Treatments								3,206	3,206				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								3,703	3,703				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								922	922				
2. Restorative Treatments													
C. Other								7,018	7,018				
D. Total Occupational Therapy Treatments								11,643	11,643				

Report of Expenditures - Salaries & Wages

Name of Facility Senior Philanthropy of Milford O, LLC d/b/a West River Re	License No. 2404	Report for Year Ended 9/30/2022	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	172,411	2,067				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	118,078	3,762				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	458,452	22,171				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	287,112	14,196				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	75,605	1,976				
b. Other Maintenance Workers	124,354	6,372				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	40,285	1,708				
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	349,429	3,436				
b. RN						
1. Direct Care	1,179,622	18,022				
2. Administrative**	383,177	10,932				
c. LPN						
1. Direct Care	1,180,195	30,964				
2. Administrative**	19,203	564				
d. Aides and Attendants	1,310,252	60,724				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	129,293	4,587				
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	132,745	3,594				
n. Marketing						
o. Other (Specify) See Attached Schedule	182,795	4,300				
<i>A-13. Total Salary Expenditures</i>	6,143,008	189,375				

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

Name of Facility				License No.	Report for Year Ended				Page	of
Senior Philanthropy of Milford O, LLC d/b/a West River Rehab Cent				2404	9/30/2022				11	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
Senior Philanthropy of Milford O, LLC d/b/a West River Rehab Center				2404	9/30/2022			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***										
T. Kevin Cleary	172,411			Non-Discriminatory	10-1-21 thru 9-30-22	2,067	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		
Senior Philanthropy of Milford O, LLC d/b/a West F	2404	9/30/2022	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	84,508	1,408				
2. Dentist	8,721	44				
3. Pharmacist	11,522	44				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	309,043	Contract				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	72,000	498				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	136,917	Contract				
b. Other						
10. Occupational Therapist						
a. Resident Care	446,581	Contract				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	27,380	153				
2. Administrative***						
b. LPN						
1. Direct Care	370,737	3,167				
2. Administrative***						
c. Aides	747,286	11,374				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	2,214,695	16,688				

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

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

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Senior Philanthropy of Milford O, LLC d/b/a West River		2404	9/30/2022		14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
SMS Cleaning & Housekeeping Services, 4547 US Highway 9 N, Suite Q, Howell NJ 07731	Dietician	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Anuruddha Walaliyadda, MD, 12 Cooke Road, Wallingford CT 06492	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Partners Pharmacy, PO Box 9689, Uniondale, NY 11555	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Joseph Balsamo, 11 Loop Road, Clinton CT 06413	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Worldwide Staffing, LLC 175 Dwight Rd #202, Longmeadow, MA 01106	RN, LPN, Aides	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
All American Healthcare Services, 494 Broad St, 4th Flr, Newark NJ 07102	RN, LPN, Aides	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Norton and Associates, Inc, 34 Elm Street Cohasset, MA 02025	RN, LPN, Aides	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Shining Star Staffing, LLC, 67 Burnside Avenue East Hartford, CT 06108	RN, LPN, Aides	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Grandison Management, 1413 38th Street, Brooklyn NY 11218	RNs, LPNs, Aides	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
HealthDrive Dental Group, 01 Centerpoint Dr Suite 215 Middletown, CT 06457	Dentist	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Trinity Rehabilitation Services, LLC 72640 Fairpoint New Athens Road Saint Clairsville, OH	PT, ST, OT	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Encore Rehabilitation Services, 33533 W 12 Mile Rd., Suite 290, Farmington Hills, MI 48331	PT, ST, OT	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
		<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"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Senior Philanthropy of Milford O, LLC d/b/a We	2404	9/30/2022	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ (20,859)	(20,859)		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 52,073	52,073		
4. Social Security (F.I.C.A.)	\$ 461,520	461,520		
5. Health Insurance	\$ 487,800	487,800		
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 2,896	2,896		
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 122,640	122,640		
8. Uniform Allowance	\$ 28,267	28,267		
9. Other (<i>Specify</i>) See Attached Schedule	\$ 64,835	64,835		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 1,328,755	1,328,755		
d. Accounting and Auditing	\$ 11,242	11,242		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 49,111	49,111		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 24,211	24,211		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 48,365	48,365		
2. Cellular Phones	\$ 208	208		
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	\$			
3. Resident Day User Fee	\$ 645,083	645,083		
Subtotal	\$ 3,306,147	3,306,147		

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended		Page	of
Senior Philanthropy of Milford O, LLC d/b/a West Riv	2404	9/30/2022		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:	3,306,147	3,306,147			
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$ 321	321			
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 2,236	2,236			
5. Education Expenses Related to Seminars and Conventions	\$ 17,057	17,057			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 507	507			
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 4,141	4,141			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 5,593	5,593			
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 2,096	2,096			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 1,791	1,791			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 286	286			
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 476,265	476,265			
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$ 156,208	156,208			
C-14 Total Administrative & General Expenditures	\$ 3,972,648	3,972,648			

* 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)
	0		
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
	0		
Promotional Advertising(Disallowed on Pg 28)	\$ 5,593		
Total Other Advertising	\$ 5,593	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
	0		
CAHCF	\$ 1,749		
Amex Membership	\$ 42		
Total Dues	\$ 1,791	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
	0		
Total Contributions	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
	0		
Licnese/Permits	\$ 2,933		
Emergency Costs(detailed summary requested)	\$ 57,234		
Resident Reimbursement Lost/Stolen Items(Disallowed on Pg 28a)	\$ 222		
Overnight Service	\$ 12		
Collection Fees(Disallowed on Pg 28a)	\$ 2,282		
Late Fees/Fines/Finance Charges(Disallowed on Pg 28a)	\$ 33,287		
Bank Service Charges(All Routine)	\$ 4,906		
Financing Costs(Disallowed on Pg 28a)	\$ 921		
Background Checks	\$ 4,573		
Startup Costs(Disallowed on Pg 28a)	\$ 49,838		
Total Other Administrative and General	\$ 156,208	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Senior Philanthropy of Milford O, LLC d/	License No. 2404	Report for Year Ended 9/30/2022	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #

* 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 Senior Philanthropy of Milford O, LLC d/b/a West Riv		License No. 2404	Report for Year Ended 9/30/2022	Page 18	of 37
Item	Total	CCNH	RHNS	(Specify)	
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$ 324,728	324,728			
2. Non-Food Supplies	\$ 17,267	17,267			
3. Other (Specify) _____	\$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 166,222	166,222			
c. Other (Specify) _____	\$				
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 508,217	508,217			
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 type="radio"/> Yes	<input checked="" 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 type="radio"/> Yes	<input checked="" type="radio"/> No			If yes, specify cost.
K. Is any revenue collected from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No			If yes, specify amt.
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
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		License No.	Report for Year Ended	Page	of
Senior Philanthropy of Milford O, LLC d/b/a West River		2404	9/30/2022	19	37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*		Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$			
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***		Lbs.			
		Amt. \$			
3. Personal clothing of residents washed, ironed, and/or processed.***		Lbs.			
		Amt. \$			
4. Repair and/or purchase of linens.***		Lbs.			
		Amt. \$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	246,647	246,647	
c. Other (Specify) Laundry Supplies		\$			
3D. Total Laundry Expenditures (3a + b + c)		\$	246,647	246,647	
3E. Laundry Questionnaire					
F.	Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" 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		License No.	Report for Year Ended		Page	of
Senior Philanthropy of Milford O, LLC d/b/a W		2404	9/30/2022		20	37
Item		Total	CCNH	RHNS	(Specify)	
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
1.	Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$				
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt. \$	74,826	74,826		
C. Other (<i>Specify</i>) Housekeeping Supplies		\$	2,078	2,078		
4D. Total Housekeeping Expenditures (4a + b + c)		\$	76,904	76,904		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from Partners Pharmacy/Specialty Rx	\$	208,515	208,515		
b.	Medicine Cabinet Drugs	\$	24,163	24,163		
c.	Medical and Therapeutic Supplies	\$	156,810	156,810		
d.	Ambulance/Limousine***	\$	140	140		
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	27,601	27,601		
f.	X-rays and Related Radiological Procedures***	\$	9,254	9,254		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	39,133	39,133		
i.	Recreation	\$	16,442	16,442		
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	39,195	39,195		
5M. Total Resident Care Expenditures (5a - 5j)		\$	521,253	521,253		

* 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)
	0		
Drug Free Expenses	\$ 985		
Operating Costs-Housekeeping - Other	\$ 408		
IV Supplies-Medicaid	\$ 5,805		
IV Drugs-Medicaid	\$ 54		
COVID Testing	\$ 8,212		
IV Drugs-Medicare(Disallowed on Pg 29a)	\$ 3,689		
IV Drugs-Managed Care(Disallowed on Pg 29a)	\$ 6,299		
IV Supplies-Managed Care(Disallowed on Pg 29a)	\$ 390		
Medical Waste Disposal	\$ 1,566		
Nursing Rental Expense(Disallowed on Pg 29a)	\$ 9,185		
Nursing Expense>Minor Equip & Supplies	\$ 2,602		
Total Other Resident Care	\$ 39,195	\$ -	\$ -

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

Name of Facility Senior Philanthropy of Milford O, LLC d/b/a West River Rehab Center			License No. 2404		Report for Year Ended 9/30/2022			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
SMS Services	Suite Q, Howell NJ 07731	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Housekeeping/Dietary Services	80,637			Var	Var
Healthcare Group Services	Suite 300, Bensalem PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Dietary/Housekeeping/Laundry	218,136			Var	Var
CWPM LLC	25 Norton Place, Plainsville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Trash Removal	33,558			22	6f
Total Lawn Care & More LLC	15 Clark St., Apt. 1 Milford, CT 06460	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Ground Maintenance	31,267			22	6a
Paychex	Rochester, NY	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Payroll Processing	20,029			16	m11
Southridge Technology	246 Federal Rd, Brookfield, CT 06804	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Computer Maintenance	17,486			16	m11
Rinaldi Linen Service	47 Commons Court, Waterbury, CT 06704	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Linen Service	175,610			19	3B
CenturyLink	100 CenturyLink Dr., Monroe, LA 71203	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Internet	14,609			16	m11
MatrixCare	PO Box 1414 Minneapolis, MN 55480	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Software Maintenance	44,818			16	m11
Oasis Healthcare Group	Suite 3B, Lakewood, NJ 08701	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Consulting Fee	190,375			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	License No.	Report for Year Ended		Page	of
Senior Philanthropy of Milford O, LLC d/b/a	2404	9/30/2022		22	37
Item	Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 180,368	180,368			
b. Heat	\$ 57,269	57,269			
c. Light & Power	\$ 108,094	108,094			
d. Water	\$ 28,571	28,571			
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 2,200	2,200			
f. Other (<i>itemize</i>)	\$ 166,932	166,932			
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 543,434	543,434			
7. Depreciation (<i>complete schedule page 23*</i>)					
a. Land Improvements	\$				
b. Building & Building Improvements	\$ 23,789	23,789			
c. Non-Movable Equipment	\$				
d. Movable Equipment	\$ 90,209	90,209			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 113,998	113,998			
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	\$ 1,002,848	1,002,848			
10. Property Taxes					
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$ 120,440	120,440			
c. Personal property taxes	\$ 5,758	5,758			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,243,044	1,243,044			

* 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)
	0		
Equipment Rental	\$ 35,176		
Equipment Minor	\$ 49,094		
Small Tools	\$ 1,677		
Pest Control	\$ 1,484		
Maintenance Contracts	\$ 6,949		
Waste Disposal	\$ 35,721		
Copier Maintenance	\$ 4,897		
Maintenance Expense>Supplies	\$ 6,292		
Maintenance Expense>Minor Equip & Supplies	\$ 18		
Maintenance Expense>Sanitation & Incineration	\$ 13,212		
Maintenance Expense>Extermination	\$ 495		
Maintenance Expense>Landscaping	\$ 11,917		
Total Other Repairs and Maintenance	\$ 166,932	\$ -	\$ -

Depreciation Schedule

Name of Facility			License No.		Report for Year Ended			Page	of			
Senior Philanthropy of Milford O, LLC d/b/a West River Rehab Center			2404		9/30/2022			23	37			
Property Item			Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals		
A. Land Improvements												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal												
B. Building and Building Improvements												
1. Acquired prior to this report period			342,780		342,780	141,187	S/L	Various	23,789			
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
B-4. Subtotal										23,789		
C. Non-Movable Equipment												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
C-4. Subtotal												
		Is a mileage logbook maintained?	Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
		Yes	No	Month	Year							
D. Movable Equipment												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. Transport Van			X		7	22	58,508		S/L	5	2,565	
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					Var	Var	1,000,091	1,000,091	841,637	S/L	Various	86,096
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative					7	22	15,712	15,712	S/L	Various	1,548	
d. Standard Resident												
e. Specialized Resident												
Total Acquired during this report period							15,712	15,712			1,548	
D-3. Subtotal												90,209
E. Total Depreciation												113,998

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
Additions:					
7/12/2022	Computer Software - Matrixcare	Administrative	\$ 867	3	\$ 63
11/19/2021	Hot Water Pump	Administrative	\$ 14,845	10	\$ 1,485
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
Total additions for Movable Equipment			\$ 15,712		\$ 1,548 *
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

Annual Report of Long-Term Care Facility

CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility			License No.		Report for Year Ended			Page	of
Senior Philanthropy of Milford O, LLC d/b/a West River Rel			2404		9/30/2022			24	37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
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 Senior Philanthropy of Milford O, LLC	License No. 2404	Report for Year Ended 9/30/2022	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description	Total				
1. Date Land Purchased					
2. Date Structure Completed					
3. If NOT Original Owner, Date of Purchase					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	120				
6. Square Footage					
7. Acquisition Cost					
a. Land					
b. Building					
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)					
b. Date Mortgage Obtained					
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 _____					
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	
245 Orange Ave LLC, 245 Orange Ave., Milford, CT 06461	Building	04/01/15	123 mos.	796,202	

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 Senior Philanthropy of Milford O, LL		License No. 2404	Report for Year Ended 9/30/2022		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
Senior Philanthropy of Milford O,		2404		9/30/2022		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$			
12. D. Other Interest Expense (Specify) Interest Expense				\$	4,339	4,339	
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	4,339	4,339	
14. Insurance							
a. Insurance on Property (buildings only)				\$	22,023	22,023	
b. Insurance on Automobiles				\$	4,624	4,624	
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$			
2. Fire and Extended Coverage				\$			
3. Other (Specify) General Liability/Crime/ Other Insurance/Patient Trust				\$	71,847	71,847	
14d. Total Insurance Expenditures (14a + b + c)				\$	98,494	98,494	
15. Total All Expenditures (A-13 thru C-14)				\$	15,572,683	15,572,683	

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Senior Philanthropy of Milford O, LLC d/b/a West River Rehab			2404	9/30/2022	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$ 446,581	446,581		
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 1,328,755	1,328,755		
10.	15	1d	Accounting	\$ 4,825	4,825		
10a.			Legal	\$ 9,586	9,586		
11.			Telephone	\$			
12.			Cellular Telephone	\$			
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.			Automobile Expense (e.g. personal use)	\$			
18.	16	m2/3	Unallowable Advertising *	\$ 5,593	5,593		
19.			Income Tax / Corporate Business Tax	\$			
20.	16	m10	Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 87,106	87,106		
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)				\$ 1,882,446	1,882,446		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Resident Reimbursement Lost/Stolen Items	\$ 222		
16	m13	Collection Fees	\$ 2,282		
16	m13	Late Fees/Fines/Finance Charges	\$ 33,287		
16	m13	Financing Costs	\$ 921		
16	m13	Startup Costs	\$ 49,838		
15	1a9	Other Benefits - Food	\$ 318		
15	1a9	Other Benefits - Misc.	\$ 238		
Total Other A&G Adjustments			\$ 87,106	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
Senior Philanthropy of Milford O, LLC d/b/a West River Rel				2404	9/30/2022	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,882,446	1,882,446		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 208,515	208,515		
28.	20	5d	Ambulance/Limousine	\$ 140	140		
29.	20	5f	X-rays, etc	\$ 9,254	9,254		
30.	20	5h	Laboratory	\$ 39,133	39,133		
31.			Medical Supplies	\$			
32.	20	5e2	Oxygen (non emergency)	\$ 27,601	27,601		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 26,521	26,521		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ 334	334		
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)				\$ 2,193,944	2,193,944		

*** 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	51	Cable TV Disallowance(See Attached)	\$ 6,958		
20	51	IV Drugs-Medicare	\$ 3,689		
20	51	IV Drugs-Managed Care	\$ 6,299		
20	51	IV Supplies-Managed Care	\$ 390		
20	51	Nursing Rental Expense(Oxygen Machine)	\$ 9,185		
Total Other Ancillary Costs			\$ 26,521	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

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

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30	IV 8	Other Rev>Miscellaneous	\$ 225		
30	IV 8	Refunds & Rebates	\$ 24		
30	IV 8	Other >Medical Records	\$ 85		
Total Other Adjustments			\$ 334	\$ -	\$ -

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			\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility		License No.		Report for Year Ended		Page	of
Senior Philanthropy of Milford O, LLC d. 2404				9/30/2022		30	37
Item				Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue							
1.	a.	Medicaid Residents (<i>CT only</i>)	\$	13,378,579	13,378,579		
	b.	Medicaid Room and Board Contractual Allowance **	\$	(5,193,957)	(5,193,957)		
2.	a.	Medicaid (<i>All other states</i>)	\$				
	b.	Other States Room and Board Contractual Allowance **	\$				
3.	a.	Medicare Residents (<i>all inclusive</i>)	\$	2,295,449	2,295,449		
	b.	Medicare Room and Board Contractual Allowance **	\$	(4,726)	(4,726)		
4.	a.	Private-Pay Residents and Other	\$	4,365,871	4,365,871		
	b.	Private-Pay Room and Board Contractual Allowance **	\$	(595,069)	(595,069)		
II. Other Resident Revenue							
1.	a.	Prescription Drugs - Medicare	\$	108,108	108,108		
	b.	Prescription Drugs - Medicare Contractual Allowance **	\$	(12,311)	(12,311)		
	c.	Prescription Drugs - Non-Medicare	\$	90,224	90,224		
	d.	Prescription Drugs - Non-Medicare Contractual Allowance **	\$				
2.	a.	Medical Supplies - Medicare	\$				
	b.	Medical Supplies - Medicare Contractual Allowance **	\$				
	c.	Medical Supplies - Non-Medicare	\$				
	d.	Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3.	a.	Physical Therapy - Medicare	\$	642,175	642,175		
	b.	Physical Therapy - Medicare Contractual Allowance **	\$	(45,581)	(45,581)		
	c.	Physical Therapy - Non-Medicare	\$	648,416	648,416		
	d.	Physical Therapy - Non-Medicare Contractual Allowance **	\$	(31,295)	(31,295)		
4.	a.	Speech Therapy - Medicare	\$	260,408	260,408		
	b.	Speech Therapy - Medicare Contractual Allowance **	\$	(26,672)	(26,672)		
	c.	Speech Therapy - Non-Medicare	\$	201,759	201,759		
	d.	Speech Therapy - Non-Medicare Contractual Allowance **	\$	(17,275)	(17,275)		
5.	a.	Occupational Therapy - Medicare	\$	940,794	940,794		
	b.	Occupational Therapy - Medicare Contractual Allowance **	\$	(56,243)	(56,243)		
	c.	Occupational Therapy - Non-Medicare	\$	726,023	726,023		
	d.	Occupational Therapy - Non-Medicare Contractual Allowance **	\$	(5,294)	(5,294)		
6.	a.	Other (<i>Specify</i>) - Medicare	\$	(1,445,688)	(1,445,688)		
	b.	Other (<i>Specify</i>) - Non-Medicare	\$	(1,039,960)	(1,039,960)		
III. Total Resident Revenue (Section I. thru Section II.)				\$	15,183,735	15,183,735	
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 (<i>Specify</i>)			\$	1,011	1,011	
6.	Private Duty Nurses' Fees			\$			
7.	Barber, Coffee, Beauty and Gift shops			\$			
8.	Other (<i>Specify</i>)			\$	(119,799)	(119,799)	
V. Total Other Revenue (1 thru 8)				\$	(118,788)	(118,788)	
VI. Total All Revenue (III +V)				\$	15,064,947	15,064,947	

* 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 II 6a	Laboratory Medicare A	\$ 50,947		
30 II 6a	IV Therapy Medicare A	\$ 5,397		
30 II 6a	X-Ray Medicare A	\$ 12,998		
30 II 6a	Sequestration Medicare A	\$ (5,402)		
30 II 6a	Contract Adj-Ancillary Medicare A	\$ (1,129,324)		
30 II 6a	Flu Shots Medicare B	\$ 2,940		
30 II 6a	Sequestration Medicare B	\$ (798)		
30 II 6a	Contract Adj-Ancillary Medicare B	\$ (380,924)		
30 II 6a	Other Ancillary Rev>Part B	\$ (392)		
30 II 6a	Other Ancillary Rev>Part B>Sequester	\$ (1,027)		
30 II 6a	Revenue Adjustments>Medicare A	\$ (103)		
Total Other Resident Revenue - Medicare		\$ (1,445,688)	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
		-		
30 II 6b	Laboratory Private	\$ 169		
30 II 6b	Laboratory Medicaid	\$ 5,164		
30 II 6b	IV Therapy Medicaid	\$ 9,104		
30 II 6b	X-Ray Medicaid	\$ 563		
30 II 6b	Laboratory Hospice	\$ 1,139		
30 II 6b	Contract Adj-Ancillary Hospice	\$ (1,393)		
30 II 6b	Laboratory Insurance	\$ 465		
30 II 6b	X-Ray Insurance	\$ 285		
30 II 6b	Contract Adj-Ancillary insurance	\$ (38,725)		
30 II 6b	Laboratory HMO	\$ 31,600		
30 II 6b	IV Therapy HMO	\$ 9,718		
30 II 6b	X-Ray HMO	\$ 8,575		
30 II 6b	Contract Adj-Ancillary HMO	\$ (1,065,389)		
30 II 6b	Other Ancillary Rev>Medicare HMO	\$ (1,235)		
Total Other Resident Revenue		\$ (1,039,960)	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
			-		
30 IV 5	Interest Income	N/A	\$ 1,011		
Total Interest Income			\$ 1,011	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
		-		
30 IV 8	Other Rev>Miscellaneous(Disallowed on Pg 29a)	\$ 225		
30 IV 8	Forgiveness of Debt(Need to confirm with Manuel what this is)	\$ (169,216)		
30 IV 8	Covid Relief Income	\$ 49,083		
30 IV 8	Refunds & Rebates(Disallowed on Pg 29a)	\$ 24		
30 IV 8	Other Rev>Medical Records(Disallowed on Pg 29a)	\$ 85		
Total Other Revenue		\$ (119,799)	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Senior Philanthropy of Milford O, LLC	2404	9/30/2022	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	(31,330)
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,602,184
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	244,993
a. _____				
b. _____				
c. _____				
d. See Schedule		244,993		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,815,847
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost <u>342,780</u>		\$	177,804
	Accum. Depreciation <u>164,976</u>	Net		
4. Leasehold Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>1,015,803</u>		\$	86,522
	Accum. Depreciation <u>929,281</u>	Net		
7. Motor Vehicles	*Historical Cost <u>58,508</u>		\$	55,943
	Accum. Depreciation <u>2,565</u>	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	(263,027)
F/S vs C/R NBV		(263,027)		
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	57,242

* 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	
31	A5	Financing Costs	\$ 11,921
31	A5	RE Taxes	\$ 34,942
31	A5	Insurance - General & Liability	\$ 119,901
31	A5	Insurance - Auto	\$ 5,835
31	A5	Workers Comp	\$ 72,394
Total Prepaid Expenses			\$ 244,993

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)			\$ -

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Senior Philanthropy of Milford O, LLC	2404	9/30/2022	32	37
Account			Amount	
Total Brought Forward:			\$	1,873,089
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>)			\$	(1,207)
Name and Address	Amount	Loan Date		
Due From>Old Owner	(1,207)	Var		
7. Other Assets (<i>itemize</i>)			\$	

See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	(1,207)
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	1,871,882

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

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Senior Philanthropy of Milford O, LLC d/b/a		2404	9/30/2022	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	1,073,726
2. Notes Payable (<i>itemize</i>)				\$	498
Current Payable>Employee>Other				459	
Current Payable>Misc. PR Deduction				292	
Current Payable>Insurance				(253)	
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>)				\$	224,991
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	33,310
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>)				\$	393,065
Accrued Expense>Medicaid>Bed Ta		(1,471)	Accrued Expenses>Work	64,816	
Accrued Expenses>Personal Property		1,291	Accrued Expenses>Healt	99,739	
Accrued Expenses>Insurance - Gene		94,569	Accrued Expenses	8,822	
Accrued Expenses>Management Fee		125,299	See Schedule		
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	1,725,590

* 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 Senior Philanthropy of Milford O, LLC d/b/	License No. 2404	Report for Year Ended 9/30/2022	Page 34	of 37
Account			Amount	
Total Brought Forward:			1,725,590	
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>)				\$ 136,388
Name and Address of Lender	Amount	Loan Date		
Due To/From>Various	136,388	Various		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ 66,088
Long Term Debt>Capital Lease		66,088		

See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 202,476
C. Total All Liabilities (Lines A-13 + B-5)				\$ 1,928,066

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

Name of Facility	License No.	Report for Year Ended	Page	of
Senior Philanthropy of Milford O, LLC	2404	9/30/2022	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			\$	120
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	386,610
6. Gain or Loss for Period			\$	(442,914)
	10/1/2021	thru	9/30/2022	
7. Total Net Worth			\$	(56,184)
C. Total Reserves and Net Worth			\$	(56,184)
D. Total Liabilities, Reserves, and Net Worth			\$	1,871,882

H. Changes in Total Net Worth

Name of Facility Senior Philanthropy of Milford O, LLC d	License No. 2404	Report for Year Ended 9/30/2022	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2021			\$	4,509,769
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	15,064,947
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	15,507,861
D. Net Income or Deficit			\$	(442,914)
E. Balance			\$	4,066,855
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
Total Expenditures Per Pg 27 \$15,572,683				
F/S vs C/R Depreciation (64,822)				
Total Expenses \$15,507,861				
2. Other (<i>itemize</i>)				
Reconciling Variance to Correct PY Ending Bala			(1,025,851)	
Prior Period Adjustment			(3,097,188)	
F-3. Total Additions			\$	(4,123,039)
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	
Name and Address (<i>No., City, State, Zip</i>)	Title	Amount		
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period			\$	(56,184)
09/30/22				

I. Preparer's/Reviewer's Certification

Name of Facility Senior Philanthropy of Milford O, LLC	License No. 2404	Report for Year Ended 9/30/2022	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
Matthew S. Bavolack				
Address Address		Phone Number		
555 Long Wharf Dr 8th Floor, New Haven, CT, 06511		203-781-9600		
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number		
Chani Licht		732-276-4140		
Contact Email Address				
chanil@ltcally.com				