State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2016

Name of Facility (as licensed) Montowese Health and Rehabilitation Center, Inc.		
Address (No. & Street, City, State, Zip Code) 163 Quinnipiac Avenue, North Haven, CT 06473		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	1015C			075017

Medicaid Provider Numbers:	CCNH	RHNS	ICF-MR
	000010157		

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

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Montowese Health and Rehabilitation Center, Inc.	1015C	9/30/2016	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Montowese Health and Rehabilitation Center, Inc. [facility name], for the cost report period beginning October 1, 2015 and ending September 30, 2016, 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) Mark Panico (Assistant Administrator)			Printed Name (Owner) Farooq Khan	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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Department of Social Services
25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Montowese Health and Rehabilitation Center, Inc.	Period Covered:		From 10/1/2015	To 9/30/2016
Address of Facility 163 Quinnipiac Avenue, North Haven, CT 06473				
Report Prepared By Wonneberger & Morgan, LLC	Phone Number (860) 202-4980		Date 2/13/2017	

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.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
(203) 624-3303	9/30/2016	2	37

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

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	1015C			075017

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Type of Ownership (Check appropriate box)

○ Proprietorship ○ LLC ○ Partnership ◉ Profit Corp. ○ Non-Profit Corp. ○ Government ○ Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Farooq Khan	00981

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

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

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation Center	1015C	9/30/2016	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
Montowese Health and Rehabilitation Center, Inc.	163 Quinnipiac Avenue North Haven, CT 06473	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Farooq H. Khan		President	40%
Eileen M. Khan		Treasurer / Secretary	30%
Genine Tannoia			30%
Names of Stockholders Owning at Least 10% of Shares			
Farooq H. Khan		President	40%
Eileen M. Khan		Treasurer / Secretary	30%
Genine Tannoia			30%

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General Information and Questionnaire
Individual Proprietorship

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ⊙ Yes ○ No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Faleena Realty, LLC	163 Quinnipiac Ave. North Haven, CT 06473	○	⊙		Realty Company	Pg 22 Line 9	1,560,000	320,844
Khan, Panico, Tannoia FLP Khan, Tannoia FLP	163 Quinnipiac Ave. North Haven, CT 06473	○	⊙		Garage Rentals - Disallowed	Pg 22 Line 9	36,912	36,912
282 Maple Avenue Associates, LLC	282 Maple Ave. North Haven, CT 06473	○	⊙		Storage Rental - Disallowed	Pg 22 Line 9	6,912	6,912
Montowese Healthcare Management Co., Inc	163 Quinnipiac Ave. North Haven, CT 06473	○	⊙		Management Company	Pg 16 Line m.12	77,000	77,000
Connecticut Handivan, Inc.	208 Quinnipiac Ave. North Haven, CT 06473	⊙	○	100%	Wheelchair Transportation	Page 20 Line C.5.d	420	420
EFK of Connecticut Inc. d/b/a Nelson Ambulance	208 Quinnipiac Ave. North Haven, CT 06473	⊙	○	100%	Ambulance Transportation	Page 20 Line C.5.d	778	778
SKMP Enterprises, Inc. d/b/a Access Ambulance	208 Quinnipiac Ave. North Haven, CT 06473	⊙	○	100%	Wheelchair Transportation	Page 20 Line C.5.d		
Nelcon Service Center	302 Maple Ave. North Haven, CT 06473	⊙	○	100%	Equipment Repairs & Maintenance	Page 22, Line 6.a	18,464	18,464
208 Quinnipiac Ave LLC	208 Quinnipiac Ave. North Haven, CT 06473	○	⊙		Rent Expense (Disallowed)	None - Disclosure Only		

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation Center, Inc.	1015C	9/30/2016	4A	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? [X] 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? [X] 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	%**				
Eileen Khan	Employee - See Page 11		✓		VP of Nursing	Pg 10 A.12.a	156,480	156,480
Saleem Khan	Employee - See Page 11		✓		Physical Plant Manager	Pg 10 A.7.b	54,200	54,200
Genine Tannoia	Employee - See Page 11		✓		Director of Nursing	Pg 10 A.12.a	137,532	137,532
Farooq Khan	Employee - See Page 12		✓		Administrator	Pg 10 A.2	314,472	314,472
Mark Panico	Employee - See Page 12		✓		Asst Administrator / Controller	Pg 10 A.3	132,410	132,410
Dominic Rivera	Employee - See Page 11	✓			Maintenance	Pg 10 A.7.b	995	995

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation Center, Inc.	1015C	9/30/2016	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Great American Leasing	○	⊙	Copier - Bizhub 284	08/01/15	48 Months	3,786	4,494
Great American Leasing	○	⊙	Copier - Bizhub 36	03/22/13	36 Months	1,476	712
Lease Direct	○	⊙	Copier - Bizhub C364e	06/11/14	36 Months	4,815	4,815
	○	⊙					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ○ No **Total ***** 10,021

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

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on and Questionnaire

Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitati	1015C	9/30/2016	7	37

The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Wonneberger & Morgan, LLC	
2 O'Conner & Davies	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Monthly Accounting, FS Review Preparation, Medicare and Medicaid Cost Report Preparation	$ 39,425
2	Reviewed Financial Statements and Federal & State Tax Returns	$ 15,500
3		$
4		$
		Charge for Services Provided $ 54,925

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

⊙ Yes ○ No Pg 15, Line 1.d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Updike, Kelly & Spellacy	
2	
3	
4	
5	

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	Refinancing of Debt	$ 322
2		$
3		$
4		$
5		$
		Charge for Services Provided $ 322

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

⊙ Yes ○ No Pg 15, Line 1.e

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Schedule of Resident Statistics

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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	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	103	103			103	103						
B. As of midnight of THIS report period	97	97							97	97		
3. Total Number of Days Care Provided During Period												
A. Medicare	16,165	16,165			12,576	12,576			3,589	3,589		
B. Medicaid (Conn.)	7,212	7,212			5,616	5,616			1,596	1,596		
C. Medicaid (other states)												
D. Private Pay	1,211	1,211			978	978			233	233		
E. State SSI for RCH												
F. Other (Specify)	12,188	12,188			8,776	8,776			3,412	3,412		
G. Total Care Days During Period (3A thru F)	36,776	36,776			27,946	27,946			8,830	8,830		
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												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	36,776	36,776			27,946	27,946			8,830	8,830		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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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						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

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

Change in Resident Days	CCNH	RHNS	(Specify)
1st change			
2nd change			
3rd change			
4th change			

6. Number of Residents and Rates on September 30 of Cost Year

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	39	17		41				
Per Diem Rate								
a. One bed rm.	RUX - $919	241.21		490.00				
b. Two bed rms.	PA1 - $230	241.21		440.00				
c. Three or more bed rms.	N/A	N/A		N/A				

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	Out-Patient
A. Medicare - Part B	4,742	2,276		2,466
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	2,810	2,810		
C. Other	80,694	76,659		4,035
D. ***Total Physical Therapy Treatments***	88,246	81,745		6,501
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	168	119		49
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	176	176		
C. Other	3,296	3,261		35
D. ***Total Speech Therapy Treatments***	3,640	3,556		84
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	2,245	2,225		20
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	2,412	2,412		
C. Other	71,137	71,072		65
D. ***Total Occupational Therapy Treatments***	75,794	75,709		85

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation Center, Inc.	1015C	9/30/2016	10	37

Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	$ 314,472	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	$ 132,410	2,553				
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	$ 450,355	22,701				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	$ 396,391	27,300				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	$ 216,728	9,414				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	$ 784	41				
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	$ 395,719	6,279				
b. RN						
1. Direct Care	$ 1,403,050	38,907				
2. Administrative**	$ 381,443	8,542				
c. LPN						
1. Direct Care	$ 977,243	36,617				
2. Administrative**	$ 38,400	1,187				
d. Aides and Attendants	$ 1,629,800	114,952				
e. Physical Therapists	$ 1,097,051	35,531				
f. Speech Therapists	$ 100,327	2,429				
g. Occupational Therapists	$ 959,884	27,755				
h. Recreation Workers	$ 95,811	5,855				
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	$ 65,219	3,079				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	$ 8,655,087	345,222				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

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

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

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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										
Eileen Khan	156,480			Standard Benefits with Owner's Life Insurance	VP of Nursing	2,080	A.12.a			
Genine Tannoia	137,532			Standard Benefits Package	Director of Nursing	2,080	A.12.a			
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).										
Saleem Khan	54,200			Standard Benefits Package	Physical Plant Manager	1,040	A.7.b			
Dominic Rivera	596			Standard Benefits Package	Maintenance Staff	57	A.7.b			

* 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.

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation Center, Inc.	1015C	9/30/2016	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* **										
Farooq Khan	314,472			Standard Benefits with Owner's Life Insurance	Adminstrator	2,080	A.2			
Section IV - Assistant Administrators										
Mark Panico	132,410			Standard Benefits Package	Asst Administrator	2,553	A.3			

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation Center, Inc.	1015C	9/30/2016	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist	$ 9,882	198				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	$ 120,155	2,670				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	$ 36,000	360				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)	$ 3,000	30				
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	$ 12,164	193				
b. Other						
10. Occupational Therapist						
a. Resident Care	$ 118,305	1,577				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	$ 299,506	5,028				

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

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

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

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CSP-14 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation Center, Inc.	1015C	9/30/2016	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Omnicare	Pharmacist	○	⊙	
Foremost Rehab of CT	PT, ST, OT	○	⊙	
Dr. Bjorn Ringstad	Medical Director / Infection Control	○	⊙	
Dr. Xiaoming Hong	Medical Director / Infection Control	○	⊙	
Dr. Quiyam Muijtaba	Infection Control	○	⊙	
Dr. Walaliyadda	Infection Control	○	⊙	
Dr. Dharini Sun	Infection Control	○	⊙	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation Center, Inc	1015C	9/30/2016	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	249,678	249,678		
2. Disability Insurance	$				
3. Unemployment Insurance	$	146,222	146,222		
4. Social Security (F.I.C.A.)	$	601,721	601,721		
5. Health Insurance	$	720,855	720,855		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	3,026	3,026		
7. Pensions (Non-Discriminatory)	$	85,258	85,258		
(not-owners and not-operators)					
8. Uniform Allowance	$	937	937		
9. Other (*Specify*)	$	7,909	7,909		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	211,439	211,439		
d. Accounting and Auditing	$	54,925	54,925		
e. Legal (*Services should be fully described on Page 7)*	$	322	322		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$	5,996	5,996		
g. Office Supplies	$	110,540	110,540		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	11,924	11,924		
2. Cellular Phones	$	9,976	9,976		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$	250	250		
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$	2,240	2,240		
See Attached Schedule					
3. Resident Day User Fee	$	270,035	270,035		
Subtotal	$	2,493,253	2,493,253		

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

(Carry Subtotals forward to next page)

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
Employee Physicals	2,515		
Employee Gym Memberships	1,400		
Lunch - Monthly Manager Meetings	3,994		
-	-		
Total	$ 7,909	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Sales Tax	2,240		
Total	$ 2,240	$ -	$ -

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation Center, Inc.	1015C	9/30/2016	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,493,253	2,493,253		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	2,467	2,467		
3. Gifts to Staff and Residents	$	8,738	8,738		
4. Employee Travel	$	5,338	5,338		
5. Education Expenses Related to Seminars and Conventions	$	45,022	45,022		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	2,078	2,078		
2. Advertising Telephone Directory (*all such expenses*)***	$	14,298	14,298		
3. Advertising Other (*Specify*)***	$	8,823	8,823		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$	9,133	9,133		
7. Postage	$	7,476	7,476		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	8,619	8,619		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	1,135	1,135		
9. Subscriptions	$	6,437	6,437		
10. Contributions***	$	2,445	2,445		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	194,560	194,560		
12. Administrative Management Services**	$	77,000	77,000		
13. Other (*Specify*)	$	113,316	113,316		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	3,000,138	3,000,138		

* 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)
Advertising - Promotional	8,823		
-	-		
Total Other Advertising	$ 8,823	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
ALTCFM	80		
CAHCF	8,539		
-	-		
-	-		
-	-		
Total Dues	$ 8,619	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Contributions	2,445		
-	-		
Total Contributions	$ 2,445	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Charges	15,282		
Bank Fees - Credit Card	13,360		
Licenses	2,945		
A&G Minor Equipment	10,909		
EE Background Checks	3,175		
-	-		
Disallowed Expenses	-		
Disallowed Expenses	18,432		
CBIA Dues	2,687		
Fines and Penalties	8,785		
Patient Cable TV Expense	33,490		
Auto Lease - Owners	14,475		
ING Erisa - Legal Refund	(10,224)		
-	-		
-	-		
-	-		
Total Other Administrative and General	$ 113,316	$ -	$ -

Schedule of Bank Fees

Description	CCNH	RHNS	(Specify)
Citizens Bank - Checking Fees			
October	1,134		
November	1,168		
December	1,154		
January	1,164		
February	1,373		
March	1,109		
April	1,398		
May	1,354		
June	1,362		
July	1,329		
August	1,369		
September	1,368		
Total Bank Fees	$ 15,282	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health and Rehabilitation Cer	1015C	9/30/2016	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 #
Montowese Healthcare Management Co.	77,000	Administrative, Property, In-Patient and Out-Patient Therapy	Pg 16 Line m.12

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

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CSP-18 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health and Rehabilitation Center, Inc.	1015C	9/30/2016	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	401,515	401,515		
2. Non-Food Supplies	$	25,618	25,618		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	221,670	221,670		
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	648,803	648,803		

2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals:	Total no. of meals served per day:*	302	302		

H.	Is cost of employee meals included in 2E?	⊙ Yes	○ No		
I.	Did you receive revenue from employees?	⊙ Yes	○ No	If yes, specify amt.	$254
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				Pg 30 / L IV.1
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	○ Yes	⊙ No	If yes, specify cost.	
L.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.	
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.	
O.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.	
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.
** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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CSP-19 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health and Rehabilitation Center, Inc.	1015C	9/30/2016	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $	32,650	32,650		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	121,515	121,515		
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	154,165	154,165		

3F.	Laundry Questionnaire			
G.	Is cost of employee laundry included in 3E?	○ Yes	⊙ No	If yes, specify cost.
H.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	○ Yes	⊙ No	If yes, specify cost.
K.	Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
L.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3E.

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

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

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CSP-20 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation Center, I	1015C	9/30/2016	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	65,023	65,023		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	390,215	390,215		
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	455,238	455,238		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	986,198	986,198		
b. Medicine Cabinet Drugs		$	114,416	114,416		
c. Medical and Therapeutic Supplies		$	537,618	537,618		
d. Ambulance/Limousine***		$	1,156	1,156		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	48,050	48,050		
f. X-rays and Related Radiological Procedures***		$	97,133	97,133		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	178,559	178,559		
i. Recreation		$	3,468	3,468		
j. Other (Specify)**** See Attached Schedule		$	168,226	168,226		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	2,134,824	2,134,824		

* 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.

Resident Care - Medical and Therapeutic Supplies - Chargeable

Description	CCNH	RHNS	(Specify)
PT Supplies	20,506		
OT Supplies	3,913		
ST Supplies	177		
ACP - Equipment Rental	28,378		
Medical Supplies	131,357		
Specialized Equip Rental	84,440		
IV Drug Expense - Med A	123,311		
IV Drug Expense - Other	145,536		
-	-		
-	-		
Total Other Resident Care	$ 537,618	$ -	$ -

Schedule of Other Resident Care

Description	CCNH	RHNS	-
Nursing Supplies - Nursing	145,439		
Nursing Supplies - Disposable Gloves	14,400		
Nursing - Minor Equipment	1,456		
PPS Expense APRN Visits	3,776		
Patient Newspapers	1,420		
Miscellaneous Patient Expenses	1,735		
-	-		
-	-		
Total Other Resident Care	$ 168,226	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation Center, Inc.	1015C	9/30/2016	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
Paychex		○	⊙		Payroll Services	$ 54,546			16	m.11
Harmony Healthcare Inc.		○	⊙		Medicare Consulting	$ 118,920			16	m.11
SigmaCare		○	⊙		HER Software Service	$ 20,405			16	m.11
Advantage Maintenance		○	⊙		Dietary Services	$ 155,613			18	2.b
Sodexo		○	⊙		Dietary Services	$ 66,057			19	3.b
Advantage Maintenance		○	⊙		Laundry Services	$ 121,515			20	4.b
Advantage Maintenance		○	⊙		Housekeeping Services	$ 390,215			22	6.f
Kone Inc.		○	⊙		Elevator Maintenance	$ 12,776			22	6.f
WJ Dornfield		○	⊙		Heating & Air Conditioning	$ 9,920			22	6.f
AllWaste		○	⊙		Trash Services	$ 32,442			22	6.f
Stericycle		○	⊙		Medical Waste Services	$ 18,171			22	6.f
Supreme Copy		○	⊙		Copier Maintenance	$ 14,132			22	6.f
		○	⊙							
		○	⊙							

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health and Rehabilitation Center,	1015C	9/30/2016	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	116,605	116,605		
b. Heat	$	91,296	91,296		
c. Light & Power	$	121,338	121,338		
d. Water	$	47,550	47,550		
e. Equipment Lease (*Provide detail on page 6*)	$	10,021	10,021		
f. Other (*itemize*)	$	221,380	221,380		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	608,190	608,190		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$				
d. Movable Equipment	$	44,933	44,933		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	44,933	44,933		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	162,781	162,781		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	162,781	162,781		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	1,603,824	1,603,824		
10. Property Taxes					
a. Real estate taxes paid by owner	$	134,830	134,830		
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	13,372	13,372		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,959,740	1,959,740		

* 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)
Supplies - Maintenance	80,498		
Minor Equipment - TV	695		
Minor Furniture & Equipment	4,079		
Purchased Services Under $10,000 Per Vendor	-		
Purchase Service - Maintenance	5,836		
Purch Serv - Meriden Fire & Safety	1,007		
Purch Serv - Fire Alarm Monitoring	2,957		
Purch Serv - Pittney Bowes	2,160		
Purch Serv - Kinsley Power	2,573		
Purch Serv - Pro Shred	1,840		
Purch Serv - Ejector Pit Pump Out	1,032		
Purch Serv - Simplex Grinnell	486		
Purch Serv - GDC Medical Electronics	6,828		
Purchased Serv - Verathon	1,290		
Purch Serv - Other	8,975		
Purch Serv - Hungerford Pump Service	2,193		
Purch Serv - UTMC	5,100		
Purch Serv - Life Systems	6,390		
-	-		
Purchased Services Over $10,000 - Page 21	-		
Purch Serv - Elevator	12,776		
Purch Serv - WJ Dornfield	9,920		
Purch Serv - Trash Services	32,442		
Purch Serv - Medical Waste	18,171		
Purch Serv - Supreme Copy	14,132		
Total Other Repairs and Maintenance	$ 221,380	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation Center, Inc.	1015C	9/30/2016	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	209,556		209,556					
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	7,043,342		7,043,342					
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					1,358,863		1,358,863	1,191,743			43,674	
b. Disposals (attach schedule)					(600,508)			(600,508)				
c. Acquired during this report period (attach schedule)					31,229		31,229				1,259	
D-3. Subtotal												44,933
E. ***Total Depreciation***												44,933

Montowese Health and Rehabilitation Center, Inc.
9/30/2016

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Land Improvements		$ -		$ -	*
Deletions:					
Total deletions for Land Improvements		$ -		$ -	**

***Ties to Page 23, Line A3**
****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Building Improvements		$ -		$ -	*
Deletions:					
Total deletions for Building Improvements		$ -		$ -	**

***Ties to Page 23, Line B3**
****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Non-Movable Equipment		$ -		$ -	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

***Ties to Page 23, Line C3**
****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
3/18/2016	Used Hospital Beds (12)	3,500	12	146	
3/23/2016	Office Furniture	5,599	20	140	
6/15/2016	Clinitron Bed	15,963	12	665	
8/22/2016	Recliner Chairs (3)	6,167	10	308	
Total additions for Movable Equipment		$ 31,229		$ 1,259	*
Deletions:					
	Cost Year 1996	(12,500)		-	
	Cost Year 1998	(47,829)			
	Cost Year 1999	(65,614)			
	Cost Year 2000	(66,410)			
	Cost Year 2001	(102,956)			
	Cost Year 2002	(95,431)			
	Cost Year 2003	(25,334)			
	Cost Year 2004	(64,208)			
	Cost Year 2005	(35,524)			
	Cost Year 2006	(20,730)			
	Cost Year 2007	(7,590)			
	Cost Year 2008	(17,298)			
	Cost Year 2009	(17,212)			
	Cost Year 2010	(7,363)			
	Cost Year 2011	(10,473)			
	Cost Year 2012	(4,036)			
Total deletions for Movable Equipment		$ (600,508)		$ -	**

***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:					
1/18/2016	Smoking Area Auto Doors	11,459	10	573	
12/16/2015	Fan Coil Unit	9,944	15	331	
1/28/2016	Fan Coil Unit	9,465	15	316	
7/6/2016	Awning - Smoking Area	3,039	15	101	
8/22/2016	Fan Coil Unit	9,944	15	331	
12/5/2015	Parking Lot Repairs	8,100	8	506	
6/29/2016	Parking Lot Repairs	15,525	8	971	
Total additions for Leasehold Improvement		$ 67,476		$ 3,129	*
Deletions:					
	Cost Year 1991	(85,236)			
	Cost Year 1992	(23,969)			
	Cost Year 1993	(6,633)			
	Cost Year 1994	(23,355)			
	Cost Year 1995	(23,692)			
	Cost Year 1997	(14,866)			
	Cost Year 1998	(8,317)			
	Cost Year 1999	(43,090)			
	Cost Year 2000	(81,510)			
	Cost Year 2001	(47,754)			
	Cost Year 2002	(31,756)			
	Cost Year 2003	(86,399)			
	Cost Year 2004	(85,497)			
	Cost Year 2005	(71,631)			
	Cost Year 2006	(7,270)			
	Cost Year 2007	(1,542)			
Total deletions for Leasehold Improvement		$ (642,517)		$ -	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation Center, Inc.	1015C	9/30/2016	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
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				2,797,341	1,779,442			159,652	
2. Disposals (attach schedule)				(642,517)	(642,517)				
3. Acquired during this report period									
(attach schedule)				67,476				3,129	
C-4. Subtotal									162,781
D. ***Total Amortization***									162,781

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation	1015C	9/30/2016	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	1982
2. Date Structure Completed	1990
3. If **NOT** Original Owner, Date of Purchase	N/A
4. Date of Initial Licensure	05/01/82
5. Total Licensed Bed Capacity	120
6. Square Footage	60,000
7. Acquisition Cost	
a. Land	102,781
b. Building	4,751,607

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	10/18/13			
c. Interest Rate for the Cost Year	4.10%			
d. Term of Mortgage (number of years)	10			
e. Amount of Principal Borrowed	3,000,000			
f. Principal balance outstanding as of 9/30/16	2,125,000			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health and Rehabilitation	1015C	9/30/2016	26 | 37

Item	Total	CCNH	RHNS	(Specify)
12. Interest				
A. Building, Land Improvement & Non-Movable Equipment				
1. First Mortgage $				
Name of Lender / Rate				
Address of Lender 00				
2. Second Mortgage $				
Name of Lender / Rate				
Address of Lender 00				
3. Third Mortgage $				
Name of Lender / Rate				
Address of Lender 00				
4. Fourth Mortgage $				
Name of Lender / Rate				
Address of Lender 00				
B. CHEFA Loan Information				
1. Original Loan Amount $				
2. Loan Origination Date				
3. Interest Rate %				
4. Term				
5. CHEFA Interest Expense				
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5) $				

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health and Rehabilitati	1015C	9/30/2016	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 00				
2. Other (*Specify*) $				
A. Item / Rate / Amount				
Lender				
Address of Lender 00				
B. Item / Rate / Amount				
Lender				
Address of Lender 00				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $				
12. D. Other Interest Expense (*Specify*) $ See Attached Page 27A	71,689	71,689		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	71,689	71,689		
14. Insurance				
a. Insurance on Property (buildings only) $	20,907	20,907		
b. Insurance on Automobiles $	4,045	4,045		
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	39,804	39,804		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $ See Attached Page 27A	219,232	219,232		
14d. ***Total Insurance Expenditures (14a + b + c)*** $	283,988	283,988		
15. ***Total All Expenditures (A-13 thru C-14)*** $	18,271,368	18,271,368		

Schedule of Other Interest Expense

Description	CCNH	RHNS	(Specify)
Interest Exp - Citizens $1.5 M	47,405		
Interest Exp - Citizens $1.0 M	17,002		
Interest Exp - Line of Credit	1,705		
Interest Expense - Vendor	5,519		
Interest Exp - Capital Lease	58		
-	-	Disallowed	
-	-		
-	-		
-	-		
-	-		
-	-		
Total	$ 71,689	$ -	$ -

Schedule of Other Insurance Expense

Description	CCNH	RHNS	(Specify)
General Liability Policy	113,023		
General Liability - Claim Deductables	106,209		
-	-		
Total	$ 219,232	$ -	$ -

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health and Rehabilitation Center, Inc.	1015C	9/30/2016	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.	10	A.12.	Occupational Therapy	$	959,884	959,884		
4.			Other - See attached Schedule	$				
Page 13 - Professional Fees								
5.	13	B.8.e	Resident Care Physicians **	$				
6.	13	B.10.	Occupational Therapy	$	118,305	118,305		
7.			Other - See attached Schedule	$				
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.	15	C.1.c	Bad Debts	$	211,439	211,439		
10.			Accounting & Legal	$				
11.	15	C.1.h	Telephone	$	11,924	11,924		
12.	15	C.1.h	Cellular Telephone	$	8,536	8,536		
13.	15	C.1.a.	Life insurance premiums on the life of Owners, Partners, Operators	$	5,996	5,996		
14.			Gifts, flowers and coffee shops	$				
15.	16	C.1.l.	Education expenditures to colleges or universities for tuition and related costs for owners and employees	$	34,534	34,534		
16.	16	C.1.l.	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	C.1.m	Automobile Expense (e.g. personal use)	$	14,475	14,475		
18.	16	C.1.m	Unallowable Advertising *	$	23,121	23,121		
19.	15	C.1.j	Income Tax / Corporate Business Tax	$	250	250		
20.	16	C.1.m	Fund Raising / Contributions	$	2,445	2,445		
21.			Unallowable Management Fees	$	77,000	77,000		
22.			Barber and Beauty	$	9,133	9,133		
23.			Other - See attached Schedule	$	68,632	68,632		
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)	$	1,545,674	1,545,674		

* 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)
0	0	-	-		
Total Other Salaries Adjustment			$ -	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13					
Total Other Fees Adjustments			$ -	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m.8.a	Chamber of Commerce	880		
16	m.13	Disallowed Expenses	18,432		
16	m.13	CBIA Dues	2,687		
16	m.13	Fines and Penalties	8,785		
16	m.13	Patient Cable TV Expense	33,490		
16	m.13	ING Erisa - Legal Refund	(10,224)		
0	0	Medical Records Copies	14,582		
0	0	-	-		
Total Other A&G Adjustments			$ 68,632	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health and Rehabilitation Center, Inc.	1015C	9/30/2016	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	1,545,674	1,545,674		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs $	986,198	986,198		
28.			Ambulance/Limousine $	1,156	1,156		
29.			X-rays, etc $	97,133	97,133		
30.			Laboratory $	178,559	178,559		
31.			Medical Supplies $	131,357	131,357		
32.			Oxygen (non emergency) $	48,050	48,050		
33.			Occupational Therapy $	3,913	3,913		
34.			Other - See Attached Schedule $	357,063	357,063		
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 $	1,298,673	1,298,673		
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Research or Experimental Activities $				
43.	16	m.13	Radio and Television Revenue $	33,490	33,490		
44.			Vending Machine Revenue $				
45.			Purchase Discounts and Allowances $				
46.			Duplications of functions or services $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest $				
48.			Interest Income on Accounts Rec $				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule $	4,045	4,045		
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
51.			***Total Amount of Decrease (Items 1 - 50)*** $	4,685,311	4,685,311		

*** Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	C.5.c	Specialized Equip Rental	84,440		
20	C.5.c	IV Drug Expense - Med A	123,311		
20	C.5.c	IV Drug Expense - Other	145,536		
20	C.5.j	PPS Expense APRN Visits	3,776		
Total Other Ancillary Costs			$ 357,063	$ -	$ -

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)
22	C.8.a	Rent Expense	1,560,000		
22	C.8.a	Realty Company - Interest	(85,317)		
22	C.8.a	Realty Company - Depreciation	(235,527)		
-	-	**Adjusts Rent to include only the Depr and Int Exp of Realty Co**	-		
-	-	-	-		
22	C.8.a	Garage & Storage Rentals	43,824		
-	-	-	-		
22	C.6.a	Repairs & Maintenance - Equipment	11,385		
-	-	-	-		
-	-	Patient TV Purchases	-		
22	C.6.f	Minor Equipment - TV	695		
-	-	-	-		
22	C.6.a-f	Outpatient Allocation - Repairs and Maintenance	2,867		
22	C.10.a	Outpatient Allocation - Property Taxes	646		
27	C.14.a	Outpatient Allocation - Property Insurance	100		
Total Other Property Adjustments			$ 1,298,673	$ -	$ -

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	C.14.b	Auto Insurance	4,045		
-	-	-	-		
Total Other Adjustments			$ 4,045	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	12.D	-	-		
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation Ce	1015C	9/30/2016	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	3,237,027	3,237,027		
b. Medicaid Room and Board Contractual Allowance **	$	(1,441,476)	(1,441,476)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	7,142,662	7,142,662		
b. Medicare Room and Board Contractual Allowance **	$	2,909,242	2,909,242		
4. a. Private-Pay Residents and Other	$	5,960,461	5,960,461		
b. Private-Pay Room and Board Contractual Allowance **	$	12,729	12,729		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	608,017	608,017		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(608,017)	(608,017)		
c. Prescription Drugs - Non-Medicare	$	428,492	428,492		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(422,626)	(422,626)		
2. a. Medical Supplies - Medicare	$	49,151	49,151		
b. Medical Supplies - Medicare Contractual Allowance **	$	(49,151)	(49,151)		
c. Medical Supplies - Non-Medicare	$	21,385	21,385		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(21,260)	(21,260)		
3. a. Physical Therapy - Medicare	$	2,603,563	2,603,563		
b. Physical Therapy - Medicare Contractual Allowance **	$	(2,470,122)	(2,470,122)		
c. Physical Therapy - Non-Medicare	$	1,823,586	1,823,586		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(1,734,936)	(1,734,936)		
4. a. Speech Therapy - Medicare	$	252,903	252,903		
b. Speech Therapy - Medicare Contractual Allowance **	$	(243,208)	(243,208)		
c. Speech Therapy - Non-Medicare	$	227,951	227,951		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(222,288)	(222,288)		
5. a. Occupational Therapy - Medicare	$	2,301,405	2,301,405		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(2,245,537)	(2,245,537)		
c. Occupational Therapy - Non-Medicare	$	1,517,202	1,517,202		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(1,495,093)	(1,495,093)		
6. a. Other *(Specify)* - Medicare	$	(3,878)	(3,878)		
b. Other *(Specify)* - Non-Medicare	$	4,238	4,238		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	18,142,422	18,142,422		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	254	254		
2. Rental of rooms to non-residents	$				
3. Telephone	$	16,076	16,076		
4. Rental of Television and Cable Services	$	37,218	37,218		
5. Interest Income *(Specify)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$	11,267	11,267		
8. Other (*Specify*)	$	34,810	34,810		
V. Total Other Revenue (1 thru 8)	$	99,625	99,625		
VI. Total All Revenue (III +V)	$	18,242,047	18,242,047		

* *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

Page Ref	Related Exp Description	CCNH	RHNS	(Specify)
20	Oxygen - MCR A	36,067		
20	Laboratory - MCR A	95,442		
20	X-Ray - MCR A	61,146		
20	IV Therapy - MCR A	116,699		
	-	-		
20	Contractual Adj - Ancill - MCR A	(309,353)		
20	Contractual Adj - Ancill - MCR B	-		
	-	-		
20	Rate Adjustments -MCR B	(689)		
20	2% Contractual Adj - Med B	(3,190)		
Total Other Resident Revenue - Medicare		$ (3,878)	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Page Ref	Related Exp Description	CCNH	RHNS	(Specify)
20	Oxygen - MCD	75		
20	IV Therapy - MCD	2,835		
20	Laboratory - MCD	28		
20	Oxygen - INS	23,234		
20	Laboratory - INS	63,107		
20	IV Therapy - INS	134,757		
20	X-Ray - INS	26,776		
20	Oxygen - PVT	1,003		
20	Laboratory - PVT	81		
20	-	-		
20	Contractual Adj - Ancillaries - MCD	(2,937)		
20	Contractual Adj - Ancill - INS	(244,721)		
Total Other Resident Revenue		$ 4,238	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
31	Interest Income	-	-		
	-				
Total Interest Income			$ -	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
16	Medical Records Copies	14,582		
	American Express Rebate	17,000		
	Intererst Rate Swap Activity	3,228		
Total Other Revenue		$ 34,810	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation C	1015C	9/30/2016	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 400
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 3,368,401
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 16,728
4 Inventories				$ 26,092
5. Prepaid Expenses				$ 68,503
a. Prepaid Insurance		67,642		
b. Prepaid - Other		861		
c.				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 5,878
Deposits		5,878		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 3,486,002
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	209,556		$ 209,556
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost	7,043,342		$ 7,043,342
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	2,222,300		$ 922,594
	Accum. Depreciation	(1,299,706)	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	789,584		$ 153,416
	Accum. Depreciation	(636,168)	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ (2)
Rounding		(2)		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 8,328,906

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation C	1015C	9/30/2016	32	37

Account				Amount
			Total Brought Forward:	$ 11,814,908
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 (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 410,772
Due From Khan Realty LLC		406,540		
Due From Faleena Realty		4,232		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 410,772
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 12,225,680

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation Center,	1015C	9/30/2016	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 1,748,791
2. Notes Payable (*itemize*)					$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)					$ 687,021
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$ 162,516
Accrued Property Taxes	94,587				
Accrued Expenses	5,214				
Accrued Provider Tax	62,715				
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 2,598,328

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation Cente	1015C	9/30/2016	34	37

Account				Amount
			Total Brought Forward:	2,598,328
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				$ 1,839,497
3. Loans from Owners or Related Parties (*itemize*)				$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (*itemize*)				$
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ 1,839,497
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 4,437,825

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation	1015C	9/30/2016	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$ 7,252,898
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$ 7,252,898
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$ 1,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 563,278
	6. Gain or Loss for Period 10/1/2015 thru 9/30/2016	$ (29,321)
	7. Total Net Worth	$ 534,957
C.	***Total Reserves and Net Worth***	$ 7,787,855
D.	***Total Liabilities, Reserves, and Net Worth***	$ 12,225,680

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation Ce	1015C	9/30/2016	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2015			$ 583,772
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 18,242,047
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 18,271,368
D.	Net Income or Deficit			$ (29,321)
E.	Balance			$ 554,451
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
	Rounding			1
F-3.	Total Additions			$ 1
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$ 19,495
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	F Khan / E Khan / G Tannoia		19,495	
	2. Other Withdrawings *(Specify)*			$
	Purpose	Amount		
	3. Total Deductions			$ 19,495
H.	***Balance at End of Period*** 09/30/16			$ 534,957

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health and Rehabilitation	1015C	9/30/2016	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed
Wonneberger & Morgan,	LLC	2/13/2017

Printed Name of Preparer

Wonneberger & Morgan, LLC

Address	Phone Number
1781 Highland Avenue, Suite 207, Cheshire, CT 06410	(860) 202-4980

Error Check

Level	Item	Reported as		
	Page 23 - Historical Cost of Movable Eq.	789,584	is inconsistent with Page 31	789,584
	Page 23 - Accumulated Dep. of Movable Eq.	636,168	is inconsistent with Page 31	636,168
-	Page 35 - Total Liabilities, Reserves and Net Wort	12,225,680	Total Assets	12,225,680

NOTE:
If amended pages are necessary, please submit the amended pages with changes highlighted in yellow, along with a signed and notarized Page 1. As a reminder, if any expense pages have changed, which result in a net increase or decrease to total expenses, please submit the necessary amended Pages 27, 35 and 36. If any depreciation and/or amortization expenses have changed, please submit the corresponding Page 23 or 24 along with the corresponding