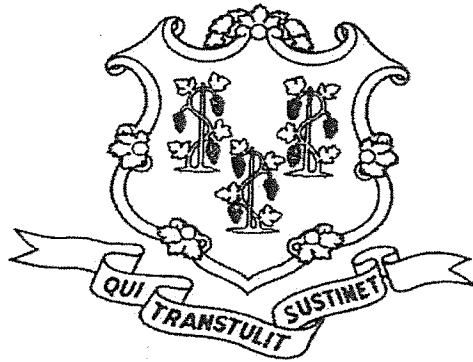


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2019

Name of Facility (as licensed) Montowese Health & Rehabilitation Center	
Address (No. & Street, City, State, Zip Code) 163 Quinnipiac Ave, North Haven, CT 06473	
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 10/1/2018	Report for Year Ending 9/30/2019

License Numbers:	CCNH 2442	RHNS	(Specify)	Medicare Provider 075017
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Medicaid Provider Numbers:	CCNH 10157	RHNS	ICF-IID
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For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2019	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 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 Montowese Health & Rehabilitation Center [facility name] for the cost report period beginning October 01, 2018 and ending September 30, 2019, 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 penalties 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
<i>Stella Akopyants</i>	<i>9/17/2020</i>	<i>[Signature]</i>	<i>9/17/2020</i>
Printed Name (Administrator)		Printed Name (Owner)	
Stella Akopyants		Lawrence Santilli	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)
	CT	<i>9/17/2020</i>	<i>[Signature]</i>
			Comm. Expires
			<i>8/1/2020</i>

Address of Notary Public
38 Linda Dr. Plainville CT 06062

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Montowese Health & Rehabilitation Center		Period Covered:	From 10/1/2018	To 9/30/2019
Address of Facility 163 Quinnipiac Ave, North Have, CT 06473				
Report Prepared By Kasie Lester		Phone Number 860-751-3949	Date 2/10/2020	
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 203-624-3303		Report for Year Ended 9/30/2019	Page 2	of 37
Name of Facility (as shown on license) Montowese Health & Rehabilitation Center		Address (No. & Street, City, State, Zip) 163 Quinnipiac Ave, North Have, CT 06473		
License Numbers:	CCNH 2442	RHNS (Specify)	Medicare Provider No. 075017	
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.				
Administrator				
Name of Administrator Stella Akopyants		Nursing Home Administrator's License No.:	001780	
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 Montowese Health & Rehabilitation Center	License No. 2442	Report for Year Ended 9/30/2019	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				
Montowese Landlord LLC	135 South Road, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>	Lease of Property	Pg 22 L9	897,794	897,794
Athena Health Care Assoc, 401k Plan	135 South Road, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>	Facility Participates in common 401k plan			
Athena Health Care System	135 South Road, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	See Attached		561,834	272,960
Procure Pharmacy	111 Executive Blvd, Farmingdale, NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	Pharmacy Services	Pg 20, 5a2, 5b	665,850	665,850
		<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.

FACILITY NAME	ADDRESS	Also Provided Goods/Services to Non-Related Parties		Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Costs Reported	Actual Cost to the Related Party
		Yes	No				
Athena Health Care	135 South Rd Farmington, CT 06032	X	<50%	Management Fees Promotion Data/Payroll Processing Painters Employee relations Licensure/surveying Insurance Health Insurance Postage Employee physicals Nursing Fill in and consulting	Pg 17 Pg 16, M3 Pg 16, M13 Pg 22, 6a Pg 16, L3 Pg 31, L A12 pg 27, L 14a Pg 15, 1a5 Pg 16, M7 Pg 16, M13 Pg 13, L 11a2	\$561,834 \$342 \$4,765 \$6,848 \$1,815 \$3,105 \$1,625 \$1,056,891 \$291 \$375 \$995	\$272,960 \$342 \$4,765 \$6,848 \$1,815 \$3,105 \$1,625 \$1,056,891 \$291 \$375 \$995
Athena Health Care Assoc 401K Plan	135 South Rd Farmington, CT 06032			Facility participates in group 401k plan			
Athena Captive LLC	135 South Rd Farmington, CT 06032		X	Workers Comp Captive	pg. 15 a1	\$283,722	\$283,722
Misc Facilities	Various Address	X	>98%	Interfacility Loan Payable	Pg. 34 Ln 3		

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility Montowese Health & Rehabilitation Center	License No. 2442	Report for Year Ended 9/30/2019	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.

NA

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

NA

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
Montowese Health & Rehabilitation Center		2442	9/30/2019			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					
Xerox, PO Box 202882, Dallas, TX 75320-2882	<input type="radio"/>	<input checked="" type="radio"/>	Copier	01/31/18	36	19,781	19,781
Pitney Bowes, PO Box 371887, Pittsburgh, PA 15250	<input type="radio"/>	<input checked="" type="radio"/>	Mail Machine	01/31/18	63	2,131	2,131
	<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 ***						21,912	

* 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 Montowese Health & Rehabilitation	License No. 2442	Report for Year Ended 9/30/2019	Page 7	of 37
The records of this facility for the period covered by this report were maintained on the following basis:				
<input checked="" type="radio"/> Accrual <input type="radio"/> Cash <input type="radio"/> Modified Cash				
Is the accounting basis for this period the same as for the previous period? <input type="radio"/> Yes <input checked="" type="radio"/> No If "No," explain.				
Facility Changed Ownership 1/25/18				
Independent Accounting Firm				
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)		
1 Marcum, LLP		185 Asylum St, 17th Fl, Hartford, CT 06103		
2 Bedford Cost Segregation Energy R&D		19 Kilton Rd, Suite 100, Bedford, NH 03110		
3				
4				
Services Provided by This Firm (<i>describe fully</i>)				
1	Audit Fee		\$	22,500
2	Cost Report		\$	2,700
3	Tax Returns		\$	7,575
4	Cost Segregation: Disallow		\$	7,000
			Charge for Services Provided	\$ 39,775
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="radio"/> Yes <input type="radio"/> No Pg 15, Line 1d				
Legal Services Information				
Name of Legal Firm or Independent Attorney			Telephone Number	
1 Mutha Cullina			203-772-7700	
2 Timothy Wall			203-265-7173	
3 Goldman, Gruder & Woods			203-899-8900	
4 Treasurer State of CT				
5 Senior Planning Services				
Address (<i>No. & Street, City, State, Zip Code</i>)				
1 265 Church St., New Haven, CT 06510				
2 PO Box 297, Wallingford, CT 06492				
3 200 Connecticut Ave, Norwalk, CT 06854				
4				
5				
Services Provided by This Firm (<i>describe fully</i>)				
1	Audit Letter: Allow		\$	601
2	Conservatorship: Disallow		\$	180
3	Collections: Disallow		\$	2,446
4	Conservatorship: Disallow		\$	900
5	Conservatorship: Disallow		\$	2,550
			Charge for Services Provided	\$ 6,677
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="radio"/> Yes <input type="radio"/> No Pg 15, Line 1e				

Schedule of Resident Statistics

Name of Facility Montowese Health & Rehabilitation Center	License No. 2442	Report for Year Ended 9/30/2019				Page 8	of 37
		Period 10/1 Thru 6/30		Period 7/1 Thru 9/30			
		Total All Levels	Total CCNH Level	Total RHNS Level	Total (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	118	118			118	118	
3. Total Number of Days Care Provided During Period							
A. Medicare	16,161	16,161			12,546	12,546	3,615
B. Medicaid (Conn.)	19,290	19,290			13,769	13,769	5,521
C. Medicaid (other states)							
D. Private Pay	2,492	2,492			2,037	2,037	455
E. State SSI for RCH							
F. Other (Specify)	1,504	1,504			1,233	1,233	271
G. Total Care Days During Period (3A thru F)	39,447	39,447			29,585	29,585	9,862
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds							
A. Medicaid Bed Reserve Days	16	16			13	13	3
B. Other Bed Reserve Days	74	74			72	72	2
5. Total Resident Days (3G + 4A + 4B)	39,537	39,537			29,670	29,670	9,867

Schedule of Resident Statistics (Cont'd)

Name of Facility Montowese Health & Rehabilitation Center			License No. 2442			Report for Year Ended 9/30/2019			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input checked="" type="radio"/> Yes <input 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	65		19		3		31						
Per Diem Rate													
a. One bed rm.	575.91		251.25		570.00		426.41						
b. Two bed rms.	575.91		251.25		520.00		426.41						
c. Three or more bed rms.	575.91		251.25		470.00		426.41						
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								4,619	4,619				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								11,546	11,546				
2. Restorative Treatments													
C. Other								45,863	45,863				
D. Total Physical Therapy Treatments								62,028	62,028				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								283	283				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								822	822				
2. Restorative Treatments													
C. Other								2,710	2,710				
D. Total Speech Therapy Treatments								3,815	3,815				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								4,583	4,583				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								10,694	10,694				
2. Restorative Treatments													
C. Other								45,316	45,316				
D. Total Occupational Therapy Treatments								60,593	60,593				

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Montowese Health & Rehabilitation Center	2442	9/30/2019	10	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)	153,877	2,090				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	332,819	14,853				
5. Dietary Service						
a. Head Dietitian	23,599	652				
b. Food Service Supervisor	64,061	2,184				
c. Dietary Workers	382,213	26,535				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	715	217				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	61,537	2,271				
b. Other Maintenance Workers	87,761	4,509				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	197	54				
9. Barber and Beautician Services						
10. Protective Services	9,110	572				
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	286,780	4,122				
b. RN						
1. Direct Care	1,374,656	34,960				
2. Administrative**	1,076,007	37,959				
c. LPN						
1. Direct Care	1,034,234	33,601				
2. Administrative**						
d. Aides and Attendants	1,687,639	105,424				
e. Physical Therapists	1,204,473	34,567				
f. Speech Therapists	107,022	2,359				
g. Occupational Therapists	763,929	21,066				
h. Recreation Workers	101,444	5,956				
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	317,589	12,059				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	9,069,662	346,010				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Medical Staff Meetings	\$ 300	2				
Total	\$ 300	2	\$ -	-	\$ -	-

State of Connecticut
 Annual Report of Long-Term Care Facility
 CSP-11 Rev. 10/2005

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

Name of Facility		License No.		Report for Year Ended		Page	of		
Montowese Health & Rehabilitation Center		2442		9/30/2019		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									
NA									
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).									
NA									

* 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) Montwese Health & Rehabilitation Center		License No. 2442	Report for Year Ended 9/30/2019		Page 12	of 37			
Name	Salary Paid		Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS (Specify)							
Section III - Administrators***									
Stella Akopyants (2/1/19-9/30/19)	98,565		Health & Life Insurance, Payroll Taxes	Day to day operations if the nursing home facility	1,410	A2			
John Sweeney (10/1/18-1/31/19)	41,897		Health & Life Insurance, Payroll Taxes	Day to day operations if the nursing home facility	680	A2			
Mark Panico	13,415								
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		
Montowese Health & Rehabilitation Center	2442	9/30/2019	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	1,620	30				
3. Pharmacist	13,220	76				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	35,091	232				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	6,730	125				
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify) See Attached Schedule						
9. Speech Therapist						
a. Resident Care	4,665	26				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	39,690	1,046				
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	300	2				
B-13 Total Fees Paid in Lieu of Salaries	101,316	1,537				

* 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 Montowese Health & Rehabilitation Center		License No. 2442	Report for Year Ended 9/30/2019	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Dr. Xioming Hong, 12 Billage Street, North Haven, CT 06473	Physician-Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Anuruddha Walaliyadda, 12 Cooke Road, Wallingford, CT 06492	Physician-Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Dharini Sun, 2690 Whitey Avenue, Hamden, CT 06518	Physician-Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
West Haven Medical Group, 322 East Main Street, Ste 1B, Branford, CT 06405	Physician	<input type="radio"/>	<input checked="" type="radio"/>		
Pact, LLC, 322 East Main Street, Ste 1B, Branford, CT 06405	Physician	<input type="radio"/>	<input checked="" type="radio"/>		
Masstex Imaging, LLC, 3 Electronics Ave, Ste 201, Danvers, MA 01923	Speech Therapy	<input type="radio"/>	<input checked="" type="radio"/>		
SDX Dysphagia Experts, 21 Waterville Rd, Avon, CT 06001	Speech Therapy	<input type="radio"/>	<input checked="" type="radio"/>		
Omnicare, Inc., Dept. 781668, PO Box 78000, Detroit, MI 48278	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>		
Procure LTC Pharmacy, 110 Bi-County Blvd, Ste 121, Farmingdale, NY 11735	Pharmacist	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners: Minority Interest	
CT Oncology, 536 Saybrook Road, Middletown, CT 0657	Physician	<input type="radio"/>	<input checked="" type="radio"/>		
Healthdrive Dental Group, 888 Worcester St., Wllesley, MA 02482	Dentist	<input type="radio"/>	<input checked="" type="radio"/>		
Yale New Haven Hospital, P.O. Box 780406, Philadelphia, PA 19178	Physician	<input type="radio"/>	<input checked="" type="radio"/>		
Athena Health Care Associates, Inc, 135 South Road, Farmington, CT	MDS Fill in	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners	
Celtic Consulting LLC, 507 East Main Street, Suite 308, Torrington, CT 06790	Consulting Services	<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
Montowese Health & Rehabilitation Center	2442	9/30/2019	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 283,722	283,722		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 99,230	99,230		
4. Social Security (F.I.C.A.)	\$ 665,449	665,449		
5. Health Insurance	\$ 821,779	821,779		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 73,110	73,110		
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 176,111	176,111		
d. Accounting and Auditing	\$ 39,775	39,775		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 6,677	6,677		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 89,284	89,284		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 14,947	14,947		
2. Cellular Phones	\$ 1,549	1,549		
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	\$ 490,439	490,439		
Subtotal	\$ 2,762,072	2,762,072		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2019		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:		2,762,072	2,762,072		
I. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	6,750	6,750		
3. Gifts to Staff and Residents	\$	10,806	10,806		
4. Employee Travel	\$	5,711	5,711		
5. Education Expenses Related to Seminars and Conventions	\$	24,700	24,700		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	3,000	3,000		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$	7,264	7,264		
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	1,510	1,510		
4. Fund-Raising***	\$				
5. Medical Records	\$	(75)	(75)		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$	25	25		
7. Postage	\$	4,007	4,007		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	10,054	10,054		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$	827	827		
10. Contributions*** See Attached Schedule	\$	3,000	3,000		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$				
12. Administrative Management Services**	\$	339,252	339,252		
13. Other (<i>Specify</i>) See Attached Schedule	\$	160,080	160,080		
C-14 Total Administrative & General Expenditures	\$	3,338,983	3,338,983		

* Do not include Subscriptions, which should go in item 9.

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	\$ 1,510		
Total Other Advertising	\$ 1,510	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
APTA	\$ 415		
CAHCF Dues	\$ 9,639		
Total Dues	\$ 10,054	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Misc	\$ 3,000		
Total Contributions	\$ 3,000	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Licenses	\$ 5,846		
Bank Charges	\$ 21,676		
Payroll Processing Fees	\$ 22,801		
Employee Physicals/Background Checks	\$ 10,313		
Data Processing/Software Maint. Fees	\$ 92,638		
PS Admin-Bookkeepers	\$ 6,806		
Total Other Administrative and General	\$ 160,080	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Montowese Health & Rehabilitation Cent	License No. 2442	Report for Year Ended 9/30/2019	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 #
Athena Health Care Assoc., Inc, 135 South Road, Farmington, CT 06032	514,018	Contract Attached to a Prior Year	See Below
Allocation of the Above	\$92,523	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2019	18	37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 346,909	346,909		
2. Non-Food Supplies	\$ 18,084	18,084		
3. Other (Specify) _____ Dishes	\$ 2,274	2,274		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 54,332	54,332		
c. Other (Specify) _____ Management Services	\$ 82,243	82,243		
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 503,842	503,842		
Item	Total	CCNH	RHNS	(Specify)
2E. Dietary Questionnaire				
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 Montowese Health & Rehabilitation Center		License No. 2442	Report for Year Ended 9/30/2019	Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$				
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. \$	131,142	131,142		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$				
c. Other (Specify) Supplies	\$	8,976	8,976		
3D. Total Laundry Expenditures (3a + b + c)	\$	140,118	140,118		
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
Montowese Health & Rehabilitation Center		2442	9/30/2019		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. \$	486,596	486,596		
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. \$				
C.	Other (<i>Specify</i>)	\$				
4D.	Total Housekeeping Expenditures (4a + b + c)	\$	486,596	486,596		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from OmniCare Pharmacy and Procure Pharmacy	\$	668,330	668,330		
b.	Medicine Cabinet Drugs	\$	29,927	29,927		
c.	Medical and Therapeutic Supplies	\$	335,933	335,933		
d.	Ambulance/Limousine***	\$	12,563	12,563		
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	59,106	59,106		
f.	X-rays and Related Radiological Procedures***	\$	48,692	48,692		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	116,443	116,443		
i.	Recreation	\$	17,028	17,028		
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	289,158	289,158		
5M.	Total Resident Care Expenditures (5a - 5j)	\$	1,577,180	1,577,180		

* 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)
Management Fee Direct	\$ 92,523		
Cable TV	\$ 33,728		
Medical Equip Rentals-Medicaid	\$ 75,863		
Physical Therapy Supplies	\$ 13,132		
Occupational Therapy Supplies	\$ 2,561		
Oxygen Equipment Rentals	\$ 39,533		
Medical Equip Rentals-Other	\$ 31,818		
Total Other Resident Care	\$ 289,158	\$ -	\$ -

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

Name of Facility		License No.		Report for Year Ended		Page of					
Montwose Health & Rehabilitation Center		2442		9/30/2019		21 37					
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***					
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line	
CWPM, LLC	25 Norton Place, Painville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>		Rubbish Removal	30,611				22	6f
Procare LTC Pharmacy	111 Executive Blvd, Farmingdale, NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners: Minority Interest	Pharmacy Services	665,850				20	5b and
ADP	PO Box 842875, Boston, MA 02284-2875	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Processing	18,681				16	m13
Executive Landscaping	PO Box 185790, Hamden, CT 06518	<input type="radio"/>	<input checked="" type="radio"/>		Landscaping and Snow Removal Services	26,694				22	6f
		<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"/>								

* 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
Montowese Health & Rehabilitation Center	2442	9/30/2019			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 165,856	165,856				
b. Heat	\$ 56,274	56,274				
c. Light & Power	\$ 142,252	142,252				
d. Water	\$ 27,113	27,113				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 21,912	21,912				
f. Other (<i>itemize</i>)	\$ 175,123	175,123				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 588,530	588,530				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 148,902	148,902				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 148,902	148,902				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 10,170	10,170				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 10,170	10,170				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 897,794	897,794				
10. Property Taxes						
a. Real estate taxes paid by owner	\$ 138,633	138,633				
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$ 13,314	13,314				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,208,813	1,208,813				

* 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)
Groundskeeping	\$ 28,766		
Rubbish Removal	\$ 32,735		
Snow Removal	\$ 17,649		
Supplies	\$ 79,967		
	\$ 16,006		
Total Other Repairs and Maintenance	\$ 175,123	\$ -	\$ -

Depreciation Schedule

Name of Facility		License No.		Report for Year Ended				Page	of
Montwese Health & Rehabilitation Center		2442		9/30/2019				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	
									Is a mileage logbook maintained?
A. Land Improvements									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
A-4. Subtotal									
B. Building and Building Improvements									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
B-4. Subtotal									
C. Non-Movable Equipment									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Movable Equipment									
1. Motor Vehicles (Specify name, model and year of each vehicle)									
									Is a mileage logbook maintained?
a.									
b.									
c.									
d.									
2. Movable Equipment									
a. Acquired prior to this report period									
b. Disposals (attach schedule)									
c. Acquired during this report period (attach schedule)									
D-3. Subtotal									
E. Total Depreciation									
							1,335	148,902	
								148,902	

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:				
11/30/2018	Electric Hospital Bed	\$ 774	12	\$ 32
11/30/2018	Electric Hospital Bed	\$ 774	12	\$ 32
12/31/2018	Chambers Dining Chairs	1395	15	47
7/31/2019	12 Window A/C Units	3828	5	383
8/31/2019	Pacific Auto Scrubber	7710	5	771
9/30/2019	3 Fly Lights	1399	10	70
Total additions for Movable Equipment		\$ 15,880		\$ 1,335 *
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:				
10/31/2018	Laundry Room Pipes Replaced	9,553.00	25.00	191.00
10/31/2018	Caulked Expansion Joints and Repaired crack in brick	6,200.00	25.00	124.00
12/31/2018	Installation of 8 Fire Doors	19,196.00	20.00	480.00
2/28/2019	Hollow Metal Doors	2,074.00	20.00	52.00
2/28/2019	Replaced zone valve and thermostat	1,074.00	10.00	54.00
2/28/2019	Replaced filters and belts	4,779.00	15.00	159.00
2/28/2019	Investigation/Testing	8,300.00	10.00	415.00
3/31/2019	Install new pump floats/BJM Pump	2,519.00	10.00	126.00
3/31/2019	Install Control Panel	2,732.00	15.00	91.00
4/30/2019	Replaced sprinkler heads	1,187.00	25.00	24.00
4/30/2019	Emergency Capex Payment	8,405.00	10.00	420.00
5/31/2019	Installed door closing devices	3,003.00	15.00	100.00
6/30/2019	Purchased and Installed Full A/C System	10,582.00	10.00	529.00
8/31/2019	Install Compressor/New filter/Contractor	3,882.00	15.00	129.00
9/30/2019	Replaced Dampers/AC Unit/5 ton compressor	12,780.00	10.00	639.00
9/30/2019	Replaced Fittings on hot water pipes	1,649.00	5.00	165.00
Total additions for Leasehold Improvement		\$ 97,915		\$ 3,698 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility		License No.		Report for Year Ended		Page		of	
Montwese Health & Rehabilitation Center		2442		9/30/2019		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	9	2018	Various	46,637	3,236	S/L	Various	6,472	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2019	Various	97,915		S/L	Various	3,698	
C-4. Subtotal									
D. Total Amortization									
									10,170
									10,170

* 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 Montowese Health & Rehabilitation C	License No. 2442	Report for Year Ended 9/30/2019	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input 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)	Conventional				
b. Date Mortgage Obtained	01/25/18				
c. Interest Rate for the Cost Year					
d. Term of Mortgage (number of years)	30				
e. Amount of Principal Borrowed	12,800,000				
f. Principal balance outstanding as of	12,623,000				
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.

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

Name of Facility		License No.	Report for Year Ended		Page	of
Montowese Health & Rehabilitation C		2442	9/30/2019		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended			Page of	
Montowese Health & Rehabilitatio		2442		9/30/2019			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)				\$	11,019	11,019		
Vender Interest=\$11,019								
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	11,019	11,019		
14. Insurance								
a. Insurance on Property (buildings only)				\$	69,483	69,483		
b. Insurance on Automobiles				\$				
c. Insurance other than Property (as specified above)								
1. Umbrella (Blanket Coverage)				\$				
2. Fire and Extended Coverage				\$				
3. Other (Specify)				\$				
14d. Total Insurance Expenditures (14a + b + c)				\$	69,483	69,483		
15. Total All Expenditures (A-13 thru C-14)				\$	17,095,542	17,095,542		

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center				2442	9/30/2019	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	\$ 763,929	763,929		
4.			Other - See attached Schedule	\$ 27,619	27,619		
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$ 6,730	6,730		
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$ 176,111	176,111		
10.			Accounting	\$ 9,500	9,500		
10a.			Legal	\$ 3,576	3,576		
11.			Telephone	\$			
12.			Cellular Telephone	\$ 823	823		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$ 10,806	10,806		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$ 19,750	19,750		
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.			Unallowable Advertising *	\$ 8,774	8,774		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 3,000	3,000		
21.			Unallowable Management Fees	\$ 190,657	190,657		
22.			Barber and Beauty	\$ 100	100		
23.			Other - See attached Schedule	\$ 31,266	31,266		
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)				\$ 1,252,641	1,252,641		

* 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)
Pg 16	M13	Purch Serv-Admin	\$ 6,806		
		Marketing Salary & Benefits	\$ 4,534		
Pg 12		Administrator Severange Package	\$ 16,279		
Total Other Salaries Adjustment			\$ 27,619	\$ -	\$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M13	Bank Charges	\$ 21,676		
16	M13	Compliance Consulting	\$ 9,157		
30	IV8	Property Insurance Claim	\$ 433		
Total Other A&G Adjustments			\$ 31,266	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Montowese Health & Rehabilitation Center			2442	9/30/2019	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,252,641	1,252,641		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$ 668,330	668,330		
28.			Ambulance/Limousine	\$ 12,563	12,563		
29.			X-rays, etc	\$ 48,692	48,692		
30.			Laboratory	\$ 116,443	116,443		
31.			Medical Supplies	\$ 12,000	12,000		
32.			Oxygen (non emergency)	\$ 59,106	59,106		
33.			Occupational Therapy	\$ 2,561	2,561		
34.			Other - See Attached Schedule	\$ 40,724	40,724		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 65,000	65,000		
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	\$ 30,128	30,128		
43.			Interest Income on Account Rec.	\$ 43	43		
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$ 51,997	51,997		
46.			Management Fees Indirect	\$ 46,220	46,220		
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)				\$ 2,406,448	2,406,448		

*** 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.

Total Other Adjustments			\$ 30,128	\$ -	\$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other 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
Montowese Health & Rehabilitation Cent 2442		9/30/2019			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (CT only)	\$ 9,016,387	9,016,387				
b. Medicaid Room and Board Contractual Allowance **	\$ (4,251,450)	(4,251,450)				
2. a. Medicaid (All other states)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (all inclusive)	\$ 4,404,858	4,404,858				
b. Medicare Room and Board Contractual Allowance **	\$ 1,509,203	1,509,203				
4. a. Private-Pay Residents and Other	\$ 5,003,949	5,003,949				
b. Private-Pay Room and Board Contractual Allowance **	\$ 121,612	121,612				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 529,769	529,769				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (516,628)	(516,628)				
c. Prescription Drugs - Non-Medicare	\$ 700,394	700,394				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (700,394)	(700,394)				
2. a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$ 5,567	5,567				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (5,567)	(5,567)				
3. a. Physical Therapy - Medicare	\$ 1,630,090	1,630,090				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (1,428,734)	(1,428,734)				
c. Physical Therapy - Non-Medicare	\$ 1,415,050	1,415,050				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (1,415,050)	(1,415,050)				
4. a. Speech Therapy - Medicare	\$ 192,265	192,265				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (168,333)	(168,333)				
c. Speech Therapy - Non-Medicare	\$ 208,425	208,425				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (208,425)	(208,425)				
5. a. Occupational Therapy - Medicare	\$ 1,645,458	1,645,458				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (1,436,453)	(1,436,453)				
c. Occupational Therapy - Non-Medicare	\$ 1,355,200	1,355,200				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (1,355,200)	(1,355,200)				
6. a. Other (Specify) - Medicare	\$					
b. Other (Specify) - Non-Medicare	\$ (77)	(77)				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 16,251,916	16,251,916				
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (Specify)	\$ 43	43				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$ 100	100				
8. Other (Specify)	\$ 4,009	4,009				
V. Total Other Revenue (1 thru 8)	\$ 4,152	4,152				
VI. Total All Revenue (III +V)	\$ 16,256,068	16,256,068				

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
NA	Retroactives	\$ (77)		
Total Other Resident Revenue		\$ (77)	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30/IV5	Interest on A/R		\$ 43		
Total Interest Income			\$ 43	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Property Damage Insurance Claim Settlement	\$ 433		
	Bad Debt Recovery	\$ 3,576		
Total Other Revenue		\$ 4,009	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Ce	2442	9/30/2019	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	382,693
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,033,192
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	3,955
4 Inventories			\$	28,792
5. Prepaid Expenses			\$	325,401
a. Prepaid Insurance	110,458			
b. Prepaid Health Insurance	2,588			
c. Prepaid Tax, Rent and Other	211,822			
d. Pitney Bowes Lease	533			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	(4,065)
8. Other Current Assets (<i>itemize</i>)			\$	(30)
AR Exchange	(30)			
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	2,769,938
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
4. Leasehold Improvements	*Historical Cost <u>144,553</u>		\$	131,148
	Accum. Depreciation <u>13,405</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>175,866</u>		\$	(46,820)
	Accum. Depreciation <u>222,686</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	592,266
Moveable Equipment Carryforward	552,500			
Project Development	39,766			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	676,594

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

(Carry Total forward to next page)

**MONTOWESE HEALTH CARE CENTER
PREPAID EXPENSES
September 30, 2019**

ACCT. # 1580

Maintenance	\$5,025.05
Licensing	\$521.90

Balance	\$5,546.95
----------------	-------------------

Cost Year		Montowese Amount	Totals
		2018 Purchased Moveable equipment	
	Cost Term	\$ 650,000 10.00	\$ 650,000
2018	Deprec	\$ 32,500	\$ 32,500
2018	Book Value	\$ 617,500	\$ 617,500
2019	Deprec	\$ 65,000	\$ 65,000
2019	Book Value	\$ 552,500	\$ 552,500
2020	Deprec	\$ 65,000	\$ 65,000
2020	Book Value	\$ 487,500	\$ 487,500
2021	Deprec	\$ 65,000	\$ 65,000
2021	Book Value	\$ 422,500	\$ 422,500
2022	Deprec	\$ 65,000	\$ 65,000
2022	Book Value	\$ 357,500	\$ 357,500
2023	Deprec	\$ 65,000	\$ 65,000
2023	Book Value	\$ 292,500	\$ 292,500
2024	Deprec	\$ 65,000	\$ 65,000
2024	Book Value	\$ 227,500	\$ 227,500
2025	Deprec	\$ 65,000	\$ 65,000
2025	Book Value	\$ 162,500	\$ 162,500
2026	Deprec	\$ 65,000	\$ 65,000
2026	Book Value	\$ 97,500	\$ 97,500
2027	Deprec	\$ 65,000	\$ 65,000
2027	Book Value	\$ 32,500	\$ 32,500
2028	Deprec	\$ 32,500	\$ 32,500
2028	Book Value	\$ -	\$ -
2029	Deprec		\$ -
2029	Book Value		\$ -
2030	Deprec		\$ -
2030	Book Value		\$ -
2031	Deprec		\$ -
2031	Book Value		\$ -
2032	Deprec		\$ -
2032	Book Value		\$ -
2033	Deprec		\$ -
2033	Book Value		\$ -
2034	Deprec		\$ -
2034	Book Value		\$ -
2035	Deprec		\$ -
2035	Book Value		\$ -
2036	Deprec		\$ -
2036	Book Value		\$ -
2037	Deprec		\$ -
2037	Book Value		\$ -
2038	Deprec		\$ -
2038	Book Value		\$ -
2039	Deprec		\$ -
2039	Book Value		\$ -

pg 29a Line 26
BS Line 242

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
		Pitney Bowes Lease	\$ 533
		Total Prepaid Expenses	\$ 533

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

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

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

Page Ref	Line Ref	Description	
		Project Development	\$ 39,766
		Total Other Other Fixed Assets (Itemize)	\$ 39,766

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
Montowese Health & Rehabilitation Ce		2442	9/30/2019	32	37
Account				Amount	
Total Brought Forward:				\$	3,446,532
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)			\$	5,709,621
5.	Investments Related to Resident Care (<i>itemize</i>)			\$	
6.	Loans to Owners or Related Parties (<i>itemize</i>)			\$	
	Name and Address	Amount	Loan Date		
7.	Other Assets (<i>itemize</i>)			\$	105,180
	Start up Costs	105,180			
	See Schedule				
D-8.	Total Investments and Other Assets (Lines D1 thru 7)			\$	5,814,801
D-9.	Total All Assets (Lines A9 + B10 + C8 + D8)			\$	9,261,333

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

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center		2442	9/30/2019	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	2,789,094
2. Notes Payable (itemize)				\$	931,000
Due from Related Party		931,000			
See Schedule					
3. Loans Payable for Equipment (Current portion) (itemize)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (Exclusive of Owners and/or Stockholders only)				\$	403,330
5. Accrued Payroll (Owners and/or Stockholders only)				\$	
6. Accrued Payroll Taxes Payable				\$	9,453
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)				\$	150,347
Acc'd Operating Expenses		25,063	Due to/from Related Part	(3,105)	
Acc'd Expenses-Sales Tax		1,109			
Provider Taxes Due		129,988			
Acc'd Health Insurance		(2,708)	See Schedule		
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	4,283,224

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

(Carry Total forward to next page)

Montowese
ACCRUED OPERATING EXP - 2170
August 31, 2019

DESCRIPTION	BALANCE
SJE	\$6,129.71
Medical Director	\$3,000.00
Medical Director	(\$2,945.71)
Insurance	(\$12,368.00)
Management Fees	\$3,928.32
IBNR Health Insurance	(\$22,807.74)
	(\$25,063.42)

G. Balance Sheet (cont'd)

Name of Facility Montowese Health & Rehabilitation Center		License No. 2442	Report for Year Ended 9/30/2019	Page 34	of 37
Account				Amount	
Total Brought Forward:				4,283,224	
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>)				\$ 3,211,135	
Name and Address of Lender	Amount	Loan Date			
Notes Pay-Mckesson	21,154				
Due to Partnership	3,189,981				
4. Other Long-Term Liabilities (<i>itemize</i>)				\$	

See Schedule					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 3,211,135	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 7,494,359	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation C	2442	9/30/2019	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	3,375,000
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(768,552)
6. Gain or Loss for Period			\$	(839,474)
	10/1/2018	thru 9/30/2019		
7. Total Net Worth			\$	1,766,974
C. Total Reserves and Net Worth			\$	1,766,974
D. Total Liabilities, Reserves, and Net Worth			\$	9,261,333

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Cen	2442	9/30/2019	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2018			\$	3,607,198
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	16,256,068
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	17,095,542
D. Net Income or Deficit			\$	(839,474)
E. Balance			\$	2,767,724
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
Health Insurance		(28,077)		
Goodwill		(315,956)		
		(656,717)		
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	(1,000,750)
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	09/30/19		\$	1,766,974

I. Preparer's/Reviewer's Certification

Name of Facility Montowese Health & Rehabilitation	License No. 2442	Report for Year Ended 9/30/2019	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 CFO	Date Signed 2/17/2020		
Printed Name of Preparer Athena Health Care Associates, Inc				
Address Address 135 South Road, Farmington, CT 06032		Phone Number 860-751-3900		
Contacted Person Regarding Additional Information Needed Regarding This Report Kasie Lester		Phone Number 860-751-3900		
Contact Email Address klester@athenahealthcare.com				