February 13, 2020

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

Dear Ms. Shaughnessy:

Enclosed please find the 2019 Medicaid Cost Report for New Milford Rehabilitation, LLC. In preparing this cost report, we did not perform any disallowances for dues expense in excess of the limits for each prescribed by your department. We also did not perform any disallowances related to physical therapy and speech therapy, which were paid for by entities other than the Medicaid Program. We did not disallow bad debts as it is netted against Private Pay Revenue. Page 23 only includes assets which were acquired by New Milford Rehabilitation subsequent to the purchase of the facility. The original purchase of building and equipment is recorded on the books of the management company at acquisition values. As this is a for-profit facility, building and non-moveable equipment value for fair rental purposes should be maintained at the prior owner basis which is recorded in the rate system for the facility. Moveable equipment assets which were acquired have been maintained for this filing at the basis of the prior owner and depreciation expense has been added to page 29 for these assets. Further, we did not disallow any depreciation or interest expense in excess of amounts previously approved via Certificate of Need or related to any prior state desk review or field audits. We believe that these disallowances are performed by the software used by your department in the preparation of the facility's rate computation report, and we do not want to create an inadvertent duplication of disallowance by calculating these adjustments. We believe this preparation methodology is in compliance with any rules and regulations of your department and the federal government.

State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2019

Name of Facility (as licensed) New Milford Rehabilitation, LLC		
Address (No. & Street, City, State, Zip Code) 30 Park Lane East, New Milford, CT 06776		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2207C			07-5416

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID

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
New Milford Rehabilitation, LLC	2207C	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 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 New Milford Rehabilitation, LLC [facility name], for the cost report period beginning October 1, 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 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
David Segal				2/12/20
Printed Name (Administrator) David Segal			Printed Name (Owner) Moshe Bernstein	
Subscribed and Sworn to before me:	State of CT	Date 2-12-2020	Signed (Notary Public) Patricia Murphy	Comm. Expires CT 1/31/2022
Address of Notary Public	12 Mountain View Ave. New Milford, CT 06776			

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility New Milford Rehabilitation, LLC	Period Covered:		From 10/1/2018	To 9/30/2019
Address of Facility 30 Park Lane East, New Milford, CT 06776				
Report Prepared By Blum, Shapiro & Company, P.C.	Phone Number 860-561-4000		Date 2/13/2020	

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.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-355-0971	9/30/2019	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
New Milford Rehabilitation, LLC	30 Park Lane East, New Milford, CT 06776

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2207C			07-5416

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.:
David Segal	002042

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
New Milford Rehabilitation, LLC	2207C	9/30/2019	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
New Milford Rehabilitation, LLC	30 Park Lane East, New Milford, CT 06776	Connecticut

Name of Partners/Members	Business Address	Title	% Owned
YMW CT, LLC	1165 King Street, Greenwich, CT 06831	Owner	7.06%
SJJJ, LLC	1165 King Street, Greenwich, CT 06831	Owner	7.06%
GW Holdings, LLC	1165 King Street, Greenwich, CT 06831	Owner	54.11%
IK Greenwich, LLC	1165 King Street, Greenwich, CT 06831	Owner	7.06%
WCTHC, LLC	1165 King Street, Greenwich, CT 06831	Owner	24.71%

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2019	3A	37

If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
N/A		

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
N/A			
Names of Stockholders Owning at Least 10% of Shares			
N/A			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2019	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility
N/A

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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	%**				
Moshe Bernstein	1165 King Street, Greenwich, CT 06831	○	⊙		Management Services	16 m12	52,500	52,500
Mordi Blass	1165 King Street, Greenwich, CT 06831	○	⊙		Management Services	16 m12	52,500	52,500
Sparkle	1165 King Street, Greenwich, CT 06831	⊙	○	33%	Housekeeping Services	20 4b	283,021	279,666
Sparkle	1165 King Street, Greenwich, CT 06831	⊙	○	33%	Laundry Services and Equipment	19 3b and 3d	103,461	102,235
Skilled Marketing Solutions	1165 King Street, Greenwich, CT 06831	⊙	○	98%	Website Services	16 line m3	1,188	1,188
NMHC Realty, LLC	1165 King Street, Greenwich, CT 06831	○	⊙		Rental Expense	22 Line 9	1,261,484	1,261,484
NMHC Realty, LLC	1165 King Street, Greenwich, CT 06831	○	⊙		Property Insurance	27 Line 14a	23,682	23,682
NMHC Realty, LLC	1165 King Street, Greenwich, CT 06831	○	⊙		Real Estate Taxes	22 Line 10b	94,834	94,834
		○	⊙					

* 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
New Milford Rehabilitation, LLC	2207C	9/30/2019	5	37

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
New Milford Rehabilitation, LLC	2207C	9/30/2019	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
RICOH/GE Capital, 100 Pearl St Fl 3, Hartford, CT 06103	○	⊙	Copier	11/14/13	60 Months	8,932	1,132
TIAA Copier, 245 Park Avenue New York, NY, 10167	○	⊙	Copier	11/09/18	63 Months	3,311	3,054
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total** *** 4,186

* 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.

LEASE AGREEMENT

TIAA Bank

Please fax completed agreement to 1-866-329-8795
Questions or need assistance? Call 1-866-550-8795

This Lease has been written in "Plain English." When we use the words Lessee, You and Your in this Lease, we mean the Lessee indicated below. When we use the words Lessor, We, Us, and Our in this Lease, We mean TIAA Commercial Finance, Inc. Our address is 10 Waterview Boulevard, Parsippany, New Jersey 07054.

LESSEE INFORMATION	Lessee Name CANDLEWOOD VALLEY HEALTH & REHABILITATION CENTER		Lease Number 20374284
	Lessee Billing Address 30 Park Ln E, New Milford, CT 06776		Lessee Phone Number (860) 355-0971 (860) 355-
	Equipment Location (if different from above)		Federal Tax ID Number 81-1029757
SUPPLIER INFORMATION	Supplier Name ("Supplier") and Address E COPIER SOLUTIONS INC. 245 PARK AVENUE NEW YORK, NY 10167		Supplier Phone Number 212-300-3582
EQUIPMENT DESCRIPTION ("Equipment")	Make/Model/Accessories	Quantity	Serial Number(s)
	Kyocera 8002i	1	
	kyocera 3645idn	1	
PURCHASE OPTION	Check one applicable box. If no box is checked or if more than one box is checked, the Fair Market Value Purchase Option will apply. ☑ Fair Market Value ☐ $1.00 Purchase Option ☐ Fixed Price Purchase Option - 10% of Total Cash Price		
TERM AND PAYMENT	Initial Lease Term (months): 63	Lease Payment: $301.00	Advance Lease Payment (Non Refundable) PLUS APPLICABLE TAX

TERMS AND CONDITIONS

1. LEASE. You agree to lease the Equipment from Us on the terms and conditions of this lease agreement ("Lease"). The Equipment will be deemed irrevocably accepted by You upon the earlier of (a) the delivery to Us of a signed Delivery and Acceptance Certificate or (b) 10 days after delivery of the Equipment to You if previously You have not given written notice to Us of Your non-acceptance. This Lease commences on the day the Equipment is delivered to You (the "Commencement Date") and the first Lease Payment shall be due on the Commencement Date or any other date that we designate, and the remaining Lease Payments will be due on the same day of each subsequent month at an address specified by Us in writing. If more than one Lease Payment is required in advance, the additional amount will be applied at the end of the initial or any renewal term. IF THIS LEASE IS REPLACING AN EXISTING LEASE, THE NEW PAYMENT MAY INCLUDE THE BALANCE OF THAT LEASE AND RESULT IN A GREATER AGGREGATE COST TO YOU. YOUR LEASE OBLIGATIONS ARE ABSOLUTE, UNCONDITIONAL AND NOT SUBJECT TO CANCELLATION, REDUCTION, SETOFF OR COUNTER CLAIM, EVEN IF THE EQUIPMENT DOES NOT WORK PROPERLY. You authorize Us to adjust the Lease Payment up or down by not more than 15% if the total amount We have paid in connection with the purchase, delivery and installation of the Equipment, including any trade-up and buyout amounts (collectively, the "Total Cash Price") differs from the estimated Total Cash Price originally assumed for documentation purposes.

2. NO WARRANTIES. You are leasing the Equipment "AS-IS" AND WE MAKE NO WARRANTIES EITHER EXPRESS OR IMPLIED, INCLUDING WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE.

3. EQUIPMENT USE AND MAINTENANCE, RESTOCKING FEE. You will keep the Equipment at the location stated above and maintain it in good working condition, eligible for manufacturer's certification, normal wear and tear excepted. You will pay for any repairs. It is solely Your duty to remove all sensitive or confidential data stored within the Equipment prior to returning it. You will pay all shipping expenses for the return of the Equipment to Us, to a location in the United States that We designate. We may charge You a restocking fee equal to two (2) Lease Payments. You agree that You will not take the Equipment out of service and have a third party pay or provide funds to pay the amounts due under this Lease.

4. ASSIGNMENT. You agree not to sell, assign or sublease either the Equipment or any right under this Lease without Our prior written consent. We may sell or assign this Lease without notice and the new owner will not be subject to any claims, defenses or setoffs that You may have.

5. TAXES AND FEES. You will pay all excise, sales and use, personal property and all other taxes and charges which may be imposed during the term of this Lease, arising from the use, acquisition, ownership or leasing of the Equipment, whether due before or after termination of this Lease. You will reimburse Us for Our administrative costs and fees associated with the preparation, filing, payment, and other costs of administering taxes associated with the Equipment. Where required by law, We will file the personal property tax returns with respect to the Equipment, and You shall pay Us in advance, and when We require, the taxes that We anticipate will be due during the year. You further agree to pay Us a fee for documenting this Lease.

6. INSURANCE. You will maintain at Your expense (a) property insurance against the loss, theft or destruction of, or damage to, the Equipment for its full replacement value, naming Us as loss payee, and (b) public liability and third party property insurance, naming Us as an additional insured, and give Us written proof of Your insurance. We reserve the right to reject Your insurance carrier. IF YOU DO NOT GIVE US EVIDENCE OF INSURANCE ACCEPTABLE TO US, WE HAVE THE RIGHT, BUT NOT THE OBLIGATION, TO OBTAIN INSURANCE COVERING OUR INTERESTS FOR THE TERM OF THIS LEASE, INCLUDING ANY RENEWAL OR EXTENSIONS. WE MAY ADD THE COSTS OF ACQUIRING AND MAINTAINING SUCH INSURANCE, AND OUR FEES FOR OUR SERVICES IN PLACING AND MAINTAINING SUCH INSURANCE (COLLECTIVELY, "INSURANCE CHARGE"), ON WHICH WE MAY EARN A PROFIT, TO THE AMOUNTS DUE FROM YOU UNDER THIS LEASE. Such insurance may duplicate coverage provided under Your existing policy. You will pay the Insurance Charge in equal installments allocated to the remaining Lease Payments. You acknowledge that We are not required to secure or maintain any insurance, and We will not be liable to You if We terminate any insurance coverage that We arrange.

7. PURCHASE OPTION; AUTOMATIC RENEWAL. If no default exists under this Lease, You will have the option at the end of the initial or any renewal term to purchase all (but not less than all) of the Equipment at the Purchase Option price shown above, plus any applicable taxes. Unless the Purchase Option price is $1.00, You must give Us at least 90 days written notice before the end of the initial Lease Term that You will purchase the Equipment or that You will return the Equipment to Us. If You do not give Us such written notice or if You do not purchase or deliver the Equipment in accordance with the terms and conditions of this Lease, this Lease will automatically renew on a monthly basis until You exercise a purchase option or deliver the Equipment to Us.

8. DEFAULT AND REMEDIES. You shall be in default under this Lease if (a) You fail to make any Lease Payment or other payment within 10 days of its due date, (b) You do not perform any of Your obligations under this Lease or any other agreement with Us or any of Our affiliates and this failure continues for 10 days or, (c) You become insolvent. If a default occurs, We may do one or more of the following: (i) terminate this Lease or any other agreement You have with Us or any of Our affiliates; (ii) require that You immediately pay to Us the balance of unpaid Lease Payments plus the present value of the Equipment's anticipated residual value discounted at 3 % per annum plus any other amounts due or to become due under this Lease; (iii) demand that You return the Equipment to Us; and (iv) exercise any other legal right or remedy that We may have. If any Lease Payment is not paid to Us within 3 days of its due date, You will owe Us a late charge not to exceed the greater of 10% of each late payment or $20.00 (or such lesser amount as is the maximum allowable under applicable law). You will pay all of Our costs and reasonable attorneys' fees associated with enforcing Our rights and pursuing Our remedies against You.

9. OWNERSHIP; UCC. Unless You have a $1.00 purchase option, We are the owner of the Equipment and this Lease is a "finance lease" as defined in Article 2A of the UCC; however, in the event this Lease is deemed to be a lease intended for security, You hereby grant to Us a first priority security interest in the Equipment.

10. INDEMNIFICATION. You are responsible for any losses, damages, claims, and actions, including reasonable attorneys' fees caused by or related to (a) the selection, installation, ownership, use, lease, or possession of the Equipment or (b) any data You store within the Equipment.

11. TRANSITION BILLING. In order to facilitate an orderly transition, including Equipment installation and training and to establish a uniform billing cycle, the "Effective Date" of the initial Lease Term will be the date after such transition, as shown on the first invoice. You agree to pay a prorated amount for the period between the Commencement Date and the Effective Date. This payment for the transition period will be based on the Lease Payment prorated on a 30-day calendar month and will be added to your first invoice.

12. MISCELLANEOUS. This is the entire agreement between the parties and supersedes all prior agreements, whether oral or written, concerning the subject matter hereof. THE EQUIPMENT WILL BE USED ONLY FOR BUSINESS PURPOSES. YOU CONFIRM THAT YOU DECIDED TO ENTER INTO THIS LEASE RATHER THAN PURCHASE THE EQUIPMENT. YOU AUTHORIZE US TO CORRECT OBVIOUS ERRORS OR SUPPLY MISSING INFORMATION IN THIS LEASE WITHOUT NOTICE TO YOU. YOU AGREE THAT THIS LEASE WILL BE GOVERNED BY THE LAWS OF THE STATE OF NEW JERSEY. YOU CONSENT TO THE JURISDICTION OF ANY STATE OR FEDERAL COURT LOCATED WITHIN NEW JERSEY. WE WILL NOT BE BOUND BY THIS LEASE UNTIL WE COUNTERSIGN IT OR BY PURCHASING THE EQUIPMENT, WHICHEVER OCCURS FIRST. A FAX OR ELECTRONIC VERSION OF YOUR SIGNATURE ON THIS LEASE WHEN RECEIVED BY US SHALL BE BINDING UPON YOU AS IF ORIGINALLY SIGNED. YOU AND WE EXPRESSLY WAIVE ANY RIGHTS TO A TRIAL BY JURY.

TIAA COMMERCIAL FINANCE, INC.		Lessee	
Lessor X Melana Davis Authorized Signature Melana Davis	12.10.18 Date	X Authorized Signature David Segal, Purchaser	11/9/18 Date
Print Name and Title Account Manager		Print Name and Title	

ACCEPTANCE OF DELIVERY

You certify that all the Equipment listed above has been furnished to You, and that delivery and installation has been fully completed and satisfactory and therefore You accept the Equipment. Further, all terms and conditions of this Lease have been reviewed and agreed to by You. Upon Your signing below, Your promises herein will be irrevocable and unconditional. We have purchased the Equipment from the above Supplier, whom You may contact for Your warranty rights, which We transfer to You for the term of this Lease. You acknowledge that We are not the manufacturer, supplier or dealer of the Equipment, and that the above Supplier is not Our agent.

X Authorized Signature David Segal, Purchaser	Date 11/9/18
Print Name and Title	

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2019	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 See attached	
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1 See attached	$ 28,850
2	$
3	$
4	$
	Charge for Services Provided $ 28,850

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

⊙ Yes ○ No Page 15 line 1d

Legal Services Information

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

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1 See attached	$ 17,200
2	$
3	$
4	$
5	$
	Charge for Services Provided $ 17,200

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

⊙ Yes ○ No Page 15 Line 1e

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation	2207C	09/30/2019	7a	37

Vendor	Description	Amount
Blum Shapiro & Company, P.C.	Medicare and Medicaid cost report preparation	12,100
Bonadio & Co LLP	401k audit	1,750
SY Consultant	Consulting	15,000
		28,850

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation	2207C	9/30/19	7b	37

Ref	Description	Amount	Disallowed
Goldman, Gruder & Woods, LLC	Collections	$ 10,495	10,495
Murtha Cullina LLP	General Legal Matters	2,880	
CT State Marshall	State Marshall Fees	3,825	3,825
		$ 17,200	$ 14,320

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2019	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	148	148			148	148			148	148		
B. On last day of THIS report period	148	148			148	148			148	148		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	132	132			132	132			131	131		
B. As of midnight of THIS report period	133	133			131	131			133	133		
3. Total Number of Days Care Provided During Period												
A. Medicare	7,061	7,061			5,033	5,033			2,028	2,028		
B. Medicaid (Conn.)	29,278	29,278			21,960	21,960			7,318	7,318		
C. Medicaid (other states)												
D. Private Pay	8,959	8,959			6,469	6,469			2,490	2,490		
E. State SSI for RCH												
F. Other (Specify) VA	2,097	2,097			1,504	1,504			593	593		
G. Total Care Days During Period (3A thru F)	47,395	47,395			34,966	34,966			12,429	12,429		
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	75	75			58	58			17	17		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	47,470	47,470			35,024	35,024			12,446	12,446		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2019	9	37

4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

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	17	79		37				
Per Diem Rate								
a. One bed rm.	N/A	N/A		N/A				
b. Two bed rms.	PPS	233.21		450.00				
c. Three or more bed rms.	N/A	N/A		N/A				

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	3,199	3,199		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	29	29		
C. Other	2,302	2,302		
D. ***Total Physical Therapy Treatments***	5,530	5,530		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	257	257		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	245	245		
D. ***Total Speech Therapy Treatments***	502	502		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,390	1,390		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	1,327	1,327		
D. ***Total Occupational Therapy Treatments***	2,717	2,717		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2019	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)	143,901	2,120				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	178,131	7,313				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	66,770	2,200				
c. Dietary Workers	449,582	28,468				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	57,609	2,120				
b. Other Maintenance Workers	70,953	4,351				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	209,780	4,157				
b. RN						
1. Direct Care	961,502	23,697				
2. Administrative**	269,537	6,639				
c. LPN						
1. Direct Care	1,627,748	55,324				
2. Administrative**	70,654	2,128				
d. Aides and Attendants	2,193,121	141,559				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	186,383	9,331				
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	256,816	9,379				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	222,713	10,123				
A-13. Total Salary Expenditures	6,965,200	308,909				

* 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**
Wages - Other Nursing Admin	222,713	10,123				
Total	$ 222,713	10,123	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Nursing Admin Purchased Services	$ 57,440	562				
Nursing Admin Purchased Services - Disallowed	$ 36,836	Disallowed				
Total	$ 94,276	562	$ -	-	$ -	-

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CSP-11 Rev. 10/2005

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

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	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										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2019	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
David Segal	143,901			Same as employees	Administrator	2,120	A2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	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	41,099	1,019				
2. Dentist	7,150	Disallowed				
3. Pharmacist	10,803	Disallowed				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	566,990	8,275				
b. Other						
6. Social Worker						
7. Recreation Worker	9,060	77				
8. Physicians						
a. Medical Director (entire facility)	42,079	207				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	12,000	Disallowed				
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
Medical Staff Meetings	70	1				
9. Speech Therapist						
a. Resident Care	91,018	1,177				
b. Other						
10. Occupational Therapist						
a. Resident Care	449,425	6,708				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care	24,440	555				
2. Administrative***						
c. Aides	1,679	44				
d. Other						
12. Other (Specify)						
See Attached Schedule	94,276	562				
B-13 Total Fees Paid in Lieu of Salaries	1,350,089	18,625				

* 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
New Milford Rehabilitation, LLC	2207C	9/30/2019	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
See attached		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
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		○	⦿	
		○	⦿	

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation	2207C	9/30/2019	14a	37

G/L Account #	Direct Care Consultant	Company/Individual Name	Full Explanation of Services	Total Fee Paid*	Total Hours Worked
69155.000	Dietician	Laura Koski	Dietary Consultation	41,099	1,019
87110.000	Dentist	CT Dental Group	Dentistry	7,150	Disallowed
85050.000	Pharmacist	Omnicare of Connecticut	Pharmacy	10,803	Disallowed
80950.000 80980.000	Physical Therapy	Preferred Therapy Solutions	Physical Therapy	566,990	8,275
61660.000	Recreation Worker	Various - see Pg. 14b	Recreation	9,060	77
87100.000	Medical Director	Ken Marici	Medical Director	42,079	207
87100.000	Rehab Director	John Mullen	Rehab Director	12,000	Disallowed
87105.000	Utilization Review	Burton R Rubin MD	Medical Staff Meeting	70	1
82950.000 82980.000	Speech Therapist -Resident Care	Preferred Therapy Solutions	Speech Therapy	91,018	1,177
81950.000 81980.000	Occupational Therapist: Resident Care	Preferred Therapy Solutions	Occupation Therapy	449,425	6,708
63320.000	Agency L.P.N.	Professional Healthcare Services LLC	LPN	24,440	555
63330.000	Aides	Towne Staffing LLC		322	15
		Geron Nursing & Respite Care, Inc.		1,357	29
				1,679	44
67850.000	Nursing Admin Purchased Services	Technical Gas Products, Inc.	Oxygen supply	1,000	Disallowed
		New Milford Medical Group, LLC	MDs	826	Disallowed
		Kenneth Marici, MD, PC	MDs	2,589	Disallowed
		Acute Care Gases	Oxygen supply	10,774	Disallowed
		Assoc. Pulmonologists Of W.CT, LLC	MDs	406	Disallowed
		Preferred Therapy Solutions	Rehab	20,554	Disallowed
		Health Drive Podiatry	MDs	508	Disallowed
		Pacey Pet, MD	MDs	179	Disallowed
				36,836	-
		Swallowing Diagnostics LLC	MDs	1,440	4
		Rosella Crowley	MDs	1,800	16
		Teresa Skinner	MDs	54,200	542
				57,440	562
			Total Fees	***1,350,089***	***18,625***

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CSP-14 Rev. 9/2002

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
New Milford Rehabilitation		2207C		9/30/2019	14b	37

Activities Entertainment

Entertainment	Description	Date	Total Paid
Bill Michael	Entertainment 10/11/2018	10/11/2018	$125.00
Danny Russo	Entertainment 10/24/2018	10/24/2018	$100.00
Danny Russo	Entertainment 10/24/2018	10/24/2018	$100.00
Larry Ayce Crasilli	Entertainment 10/18/2018	10/18/2018	$150.00
Frank Palmer	Entertainment 10/25/2018	10/25/2018	$100.00
John Pierce Campbell	Entertainment 10/30/2018	10/30/2018	$150.00
James I. Moore	Entertainment 10/01/2018	10/1/2018	$100.00
Danny Russo	Entertainment 11/01/2018	11/1/2018	$100.00
Hank Milligan	Entertainment 11/8/2018	11/8/2018	$100.00
Frank Palmer	Entertainment 11/21/2018	11/21/2018	$100.00
Joel Blumert	Entertainment 11/29/2018	11/29/2018	$100.00
Michael Hodorski	Entertainment 11/01/2018	11/1/2018	$12.00
Willie Nininger	Entertainment 11/27/2018	11/27/2018	$125.00
Robert Fink	Entertainment 12/1/2018	12/1/2018	$150.00
Frank Palmer	Entertainment 12/13/2018	12/13/2018	$100.00
Michael Hodorski	Entertainment 12/1/2018	12/1/2018	$113.00
Hank Milligan	Entertainment 12/24/2018	12/24/2018	$100.00
Larry Ayce Crasilli	Entertainment 12/20/2018	12/20/2018	$150.00
James I. Moore	Entertainment 12/27/2018	12/27/2018	$100.00
Frank Palmer	Entertainment 12/1/2018	12/1/2018	$100.00
Willie Nininger	Entertainment 12/31/2018	12/31/2018	$125.00
James I. Moore	Entertainment 12/27/2018	12/27/2018	$100.00
Joel Blumert	Entertainment 1/1/2019	1/1/2019	$100.00
Larry Ayce Crasilli	Entertainment 1/3/2019	1/3/2019	$150.00
Frank Palmer	Entertainment 1/10/2019	1/10/2019	$100.00
James I. Moore	Entertainment 1/17/2019	1/17/2019	$100.00
Danny Russo	Entertainment 1/31/2019	1/31/2019	$125.00
Willie Nininger	Entertainment 1/29/2019	1/29/2019	$150.00
Ethel Kaufman	Entertainment 1/1/2019	1/1/2019	$100.00
Candace Coates	Entertainment 2/14/2019	2/14/2019	$200.00
Danny Russo	Entertainment 2/14/2019	2/14/2019	$125.00
Frank Palmer	Entertainment 2/7/2019	2/7/2019	$100.00
Don Lowe	Entertainment 2/1/2019	2/1/2019	$100.00
Willie Nininger	Entertainment 2/28/2019	2/28/2019	$150.00
Frank Palmer	Entertainment 3/7/2019	3/7/2019	$100.00
Ethel Kaufman	Entertainment 3/14/2019	3/14/2019	$100.00
James I. Moore	Entertainment 3/21/2019	3/21/2019	$100.00
Joel Blumert	Entertainment 3/17/2019	3/17/2019	$100.00
Pierce Campbell	Entertainment 3/27/2019	3/27/2019	$150.00
Willie Nininger	Entertainment 3/26/2019	3/26/2019	$150.00
Danny Russo	Entertainment 4/4/2019	4/4/2019	$125.00
Frank Palmer	Entertainment 4/11/2019	4/11/2019	$100.00
Danny Russo	Entertainment 4/18/2019	4/18/2019	$125.00
James I. Moore	Entertainment 4/25/2019	4/25/2019	$100.00
Willie Nininger	Entertainment 4/30/2019	4/30/2019	$150.00
John Pierce Campbell	Entertainment 5/2/2019	5/2/2019	$150.00
Frank Palmer	Entertainment 5/9/2019	5/9/2019	$100.00
Tom Callinan	Entertainment 5/1/2019	5/1/2019	$185.00
Bill Michael	Entertainment 5/15/2019	5/15/2019	$125.00
Ethel Kaufman	Entertainment 5/16/2019	5/16/2019	$100.00
Bill Michael	Entertainment 5/27/2019	5/27/2019	$125.00
James I. Moore	Entertainment 5/23/2019	5/23/2019	$100.00
Brian Horberg	Entertainment 5/12/2019	5/12/2019	$100.00
Larry Ayce Crasilli	Entertainment 5/30/2019	5/30/2019	$150.00
Willie Nininger	Entertainment 5/28/2019	5/28/2019	$150.00
Frank Palmer	Entertainment 6/13/2019	6/13/2019	$100.00
Larry Ayce Crasilli	Entertainment 6/6/2019	6/6/2019	$150.00
Brian Horberg	Entertainment 6/16/2019	6/16/2019	$100.00
James I. Moore	Entertainment 6/20/2019	6/20/2019	$100.00
Ethel Kaufman	Entertainment 6/27/2019	6/27/2019	$100.00
Willie Nininger	Entertainment 6/25/2019	6/25/2019	$150.00
Danny Russo	Entertainment 7/4/2019	7/4/2019	$125.00
Robert Brophy	Entertainment 7/11/2019	7/11/2019	$100.00
James I. Moore	Entertainment 7/18/2019	7/18/2019	$100.00
Joel Blumert	Entertainment 7/26/2019	7/26/2019	$100.00
Willie Nininger	Entertainment 7/30/2019	7/30/2019	$150.00
James I. Moore	Entertainment 8/1/2019	8/1/2019	$100.00
Frank Palmer	Entertainment 8/8/2019	8/8/2019	$100.00
Bill Michael	Entertainment 8/15/2019	8/15/2019	$125.00
John Pierce Campbell	Entertainment 8/22/2019	8/22/2019	$150.00
Danny Russo	Entertainment 8/29/2019	8/29/2019	$125.00
Willie Nininger	Entertainment 8/26/2019	8/26/2019	$150.00
Danny Russo	Entertainment 9/2/2019	9/2/2019	$125.00
Danny Russo	Entertainment 9/5/2019	9/5/2019	$125.00
James I. Moore	Entertainment 9/12/2019	12/19/2009	$100.00
Joel Blumert	Entertainment 9/19/2019	9/19/2019	$100.00
Dean Snellback	Entertainment 9/26/2019	9/26/2019	$100.00
		Total Activities & Entertainment	$9,060.00

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2019	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	268,350	268,350		
2. Disability Insurance	$				
3. Unemployment Insurance	$	85,161	85,161		
4. Social Security (F.I.C.A.)	$	518,097	518,097		
5. Health Insurance	$	1,076,041	1,076,041		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	23,557	23,557		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	28,850	28,850		
e. Legal (*Services should be fully described on Page 7)*	$	17,200	17,200		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	25,539	25,539		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	28,232	28,232		
2. Cellular Phones	$	2,303	2,303		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$	720	720		
See Attached Schedule					
3. Resident Day User Fee	$	815,282	815,282		
Subtotal	$	2,889,332	2,889,332		

* 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)
Business Taxes - Disallowed	720		
Total	$ 720	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2019	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,889,332	2,889,332		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	75	75		
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$	15,829	15,829		
4. Employee Travel	$	9,590	9,590		
5. Education Expenses Related to Seminars and Conventions	$	10,207	10,207		
6. Automobile Expense (*not purchase or depreciation*)	$	8,341	8,341		
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	5,906	5,906		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	38,737	38,737		
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)***	$	1,300	1,300		
7. Postage	$	4,396	4,396		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	944	944		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	330	330		
9. Subscriptions	$	4,569	4,569		
10. Contributions***	$	640	640		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	17,194	17,194		
12. Administrative Management Services**	$	105,000	105,000		
13. Other (*Specify*)	$	107,698	107,698		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	3,220,088	3,220,088		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Business Promotions - Disallowed	$ 34,436		
Other Advertising - Disallowed	$ 4,301		
Total Other Advertising	$ 38,737	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Dues - See pg 16b	$ 944		
Total Dues	$ 944	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Boys and Girls Club - Disallowed	$ 200		
Pets for Veterans - Disallowed	$ 90		
Theatre Works of New Milford - Disallowed	$ 350		
Total Contributions	$ 640	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Employee Background Checks	$ 5,938		
Data Processing Fees	$ 17,187		
Software Maintenance	$ 56,601		
Insurance -EPLI	$ 11,265		
Insurance - Crime - Disallowed	$ 733		
A&G Small Equipment Purchase	$ 53		
Facility Licenses	$ 1,210		
Printing	$ 1,170		
Bank Charges	$ 13,541		
Total Other Administrative and General	$ 107,698	$ -	$ -

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Detail of Dues and Subscriptions

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation	2207C	9/30/2019	16b	37

Description	Total Amount	Dues	Subscriptions	Chamber of Commerce
Allscripts Healthcare, LLC	2,161		2,161	
CAHCF Membership	350	350		
The News Times	910		910	
Hearst Media Services, CT, LLC	1,137		1,137	
Language Line Services	300		300	
Netflix for Recreation	16		16	
American Express Annual Fee	45		45	
American College of Health Care Administrator's Membership	215	215		
New Milford Chamber of Commerce	330			330
SHRM Membership	189	189		
Simply Social Wound Care Membership	150	150		
Fairfield County Infection Control Nurse Membership	40	40		
	$ 5,843	$ 944	$ 4,569	$ 330

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
New Milford Rehabilitation, LLC	2207C	9/30/2019	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 #
Moshe Bernstein	52,500	Management Services	16 m12
Mordi Blass	52,500	Management Services	16 m12

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

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

Name of Facility	License No.	Report for Year Ended	Page of
New Milford Rehabilitation, LLC	2207C	9/30/2019	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	300,630	300,630		
2. Non-Food Supplies	$	24,454	24,454		
3. Other (*Specify*)_____ Chemicals / Cleaning Supplies	$	8,452	8,452		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____ Nutritional Supplements	$	7,114	7,114		
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	340,650	340,650		

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

G.	Is cost of employee meals included in 2D?	⦿ Yes	○ No	
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 meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	⦿ Yes	○ No	If yes, specify cost.
K.	Is any revenue collected from these people?	⦿ Yes	○ No	If yes, specify amt.
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	○ Yes	⦿ No	If yes, specify cost.
N.	Is any revenue collected from employees?	○ Yes	⦿ No	If yes, specify amt.
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

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

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

Name of Facility	License No.	Report for Year Ended	Page of
New Milford Rehabilitation, LLC	2207C	9/30/2019	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $	3,031	3,031		
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	273,401	273,401		
c. Other (*Specify*) Supplies $5,016 / Equipment Rental $8,366	$	13,382	13,382		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	289,814	289,814		

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2019	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.	$	31,406	31,406		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	283,021	283,021		
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	314,427	314,427		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	299,907	299,907		
Medicare $247,695; Medicaid $11,463; Managed Care $38,691; Ever Care $2,058						
b. Medicine Cabinet Drugs		$	21,372	21,372		
c. Medical and Therapeutic Supplies		$	27,274	27,274		
d. Ambulance/Limousine***		$	3,615	3,615		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	7,635	7,635		
f. X-rays and Related Radiological Procedures***		$	22,703	22,703		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	48,405	48,405		
i. Recreation		$	2,216	2,216		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)****		$	225,689	225,689		
See Attached Schedule						
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	658,816	658,816		

* 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)
Social Services Supplies	$ 116		
Nursing Admin Medical Equipment Rental - Disallowed	$ 2,284		
Specialty Mattresses - Disallowed	$ 25,689		
Nursing Admin Small Equpment Purchase - Disallowed	$ 2,713		
Cable TV - Disallowed	$ 15,029		
PT Small Equipment Purchase - Disallowed	$ 698		
OT Small Equipment Purchase - Disallowed	$ 963		
PT Equipment Rental - Disallowed	$ 26,722		
Nursing Supplies	$ 148,438		
Incontinet Care	$ 94		
Wound Care Supplies	$ 2,894		
Respriatory Supplies	$ 49		
Total Other Resident Care	$ 225,689	$ -	$ -

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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
New Milford Rehabilitation, LLC	2207C	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
Sparkle	5140 Highway 9, South Howell, NJ 07731	⊙	○	Common Ownership	Housekeeping	283,021			20	4b
Sparkle	5140 Highway 9, South Howell, NJ 07731	⊙	○	Common Ownership	Laundry Service and Equipment	103,461			19	3b, 3d
Shamrock	Road, Monroe, CT 06468	○	⊙		Grounds Maintenance	26,268			22	6F
All American Waste	P.O. Box 630, East Windsor, CT 06088	○	⊙		Trash Removal	31,840			22	6F
Smartlinx	333 Thornall St, Edison NJ 08837	○	⊙		Healthcare Software	11,552			16	M13
MatrixCare	Bin #32, PO Box 1414, Minneapolis, MN, 55480	○	⊙		Healthcare Software	44,049			16	M13
Saucier	148 North Street, Plantsville, CT 06479	○	⊙		HVAC	30,590			22	6a
Image First	310 Kuller Rd, Clifton, NJ 07011	○	⊙		Laundry Service	178,306			19	3b
Crown Care Services, Inc.	PO Box 86, Lakewood, NJ 08701	○	⊙		Document Storage	10,940			22	6F
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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
New Milford Rehabilitation, LLC	2207C	9/30/2019	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	39,386	39,386		
b. Heat	$	125,640	125,640		
c. Light & Power	$	131,886	131,886		
d. Water	$	63,287	63,287		
e. Equipment Lease (*Provide detail on page 6*)	$	4,186	4,186		
f. Other (*itemize*)	$	139,395	139,395		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	503,780	503,780		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	29,492	29,492		
c. Non-Movable Equipment	$				
d. Movable Equipment	$	21,467	21,467		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	50,959	50,959		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$				
9. Rental payments on leased real property less real estate taxes included in item 10b	$	1,261,484	1,261,484		
10. Property Taxes					
a. Real estate taxes paid by owner	$	31,414	31,414		
b. Real estate taxes paid by lessor	$	94,834	94,834		
c. Personal property taxes	$	16,020	16,020		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,454,711	1,454,711		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Trash Removal/ shredding	$ 44,720		
Service Contracts	$ 23,419		
Plant Supplies	$ 25,836		
Grounds Maintenance	$ 31,692		
Grounds Landscaping	$ 308		
Plant Equipment Rental	$ 50		
Plant Small Equipment Purchase	$ 180		
Plant Purchased Services - Disallowed	$ 3,449		
Plant Other	$ 114		
A&G Equipment Rental	$ 3,600		
Minor Decorating - Disallowed	$ 4,312		
Copy Charges	$ 1,715		
Total Other Repairs and Maintenance	$ 139,395	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	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
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	289,770		289,770	25,707	SL	Various	19,361	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	603,253		603,253		SL	Various	10,131	
B-4. Subtotal								29,492
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					89,991		89,991	24,494	SL	Various	19,535	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					17,885		17,885		SL	Various	1,932	
D-3. Subtotal												21,467
E. ***Total Depreciation***												50,959

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:					
1/31/2019	Cabinets	$ 14,615	15	$ 649	
3/31/2019	Bathroom Renovation	$ 14,452	10	$ 723	
4/30/2019	Air Survey Equipment	$ 21,199	15	$ 353	
6/30/2019	Air Conditioner	$ 118,715	15	$ 1,979	
6/30/2019	Roof	$ 288,285	15	$ 4,805	
7/31/2019	Paving	$ 145,987	15	$ 1,622	
Total additions for Building Improvements		$ 603,253		$ 10,131	*
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:					
1/31/2019	Beds	$ 3,133	5	$ 418	
2/28/2019	Beds	$ 3,575	5	$ 417	
3/31/2019	Beds	$ 2,884	5	$ 288	
5/31/2019	Beds	$ 3,383	5	$ 564	
5/31/2019	Beds	$ 2,440	5	$ 163	
7/31/2019	Beds	$ 2,470	5	$ 82	
Total additions for Movable Equipment		$ 17,885		$ 1,932	*
Deletions:					
Total deletions for Movable Equipment		$ -		$ -	**

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report period

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

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2019	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. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2019	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	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	04/01/16
4. Date of Initial Licensure	04/01/16
5. Total Licensed Bed Capacity	148
6. Square Footage	53,395
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Available upon			
b. Date Mortgage Obtained	Request			
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of 9/30/2019				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)	Available upon			
h. Date of Refinancing	Request			
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
New Milford Rehabilitation, LLC	2207C	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*)

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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
New Milford Rehabilitation, LLC	2207C	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*) $	4,252	4,252		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	4,252	4,252		
14. Insurance				
a. Insurance on Property (buildings only) $	35,283	35,283		
b. Insurance on Automobiles $	948	948		
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	14,040	14,040		
2. Fire and Extended Coverage $	1,160	1,160		
3. Other (*Specify*) $	70,106	70,106		
Liability				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	121,537	121,537		
15. ***Total All Expenditures (A-13 thru C-14)*** $	15,223,364	15,223,364		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
New Milford Rehabilitation, LLC	2207C	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 $				
4.			Other - See attached Schedule $	12,841	12,841		
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	b10a	Occupational Therapy $	449,425	449,425		
7.			Other - See attached Schedule $	73,247	73,247		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $				
10.			Accounting $				
10a.			Legal $	14,320	14,320		
11.			Telephone $				
12.	15	1h2	Cellular Telephone $	1,223	1,223		
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.	16	m3	Unallowable Advertising * $	38,737	38,737		
19.	16	1k2	Income Tax / Corporate Business Tax $	720	720		
20.	16	m10	Fund Raising / Contributions $	640	640		
21.	16	m12	Unallowable Management Fees $	105,000	105,000		
22.	16	m6	Barber and Beauty $	1,300	1,300		
23.			Other - See attached Schedule $	24,041	24,041		
Page 18 - Dietary Expenditures							
24.	30	IV5	Meals to employees, guests and others who are not residents $	613	613		
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) $	722,107	722,107		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	12m	Social Service Wages - Marketing Duties	$ 12,841		
Total Other Salaries Adjustment			$ 12,841	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	b12	Nursing Admin Purchased Services	$ 36,836		
13	b2	Dentist	$ 7,150		
13	8a	Medical Director Over Allowable	$ 6,458		
13	8c	Rehab Director Resident Care	$ 12,000		
13	b3	Pharmacist	$ 10,803		
Total Other Fees Adjustments			$ 73,247	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	13	Employee Relations	$ 15,829		
20	4b	Housekeeping Purchased Services - Disallow markup on related party service	$ 3,355		
19	3b	Laundry Purchased Services - Disallow markup on related party services	$ 1,226		
		Benefits on disallowed Salary above	$ 2,568		
16	m13	Insurance - Crime	$ 733		
16	8a	Chamber of Commerce Dues	$ 330		
Total Other A&G Adjustments			$ 24,041	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2019	29	37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	722,107	722,107		
Page 20 - Resident Care Supplies*							
27.	20	5a2	Prescription Drugs $	299,907	299,907		
28.	20	5d	Ambulance/Limousine $	3,615	3,615		
29.	20	5f	X-rays, etc $	22,703	22,703		
30.	20	5h	Laboratory $	48,405	48,405		
31.	20	5c	Medical Supplies $	27,274	27,274		
32.	20	5e2	Oxygen (non emergency) $	7,635	7,635		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	112,126	112,126		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $	(17,244)	(17,244)		
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 $	9,686	9,686		
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Other - Indirect $				
43.			Interest Income on Account Rec. $				
44.			Other - Miscellaneous Administrative $				
45.			Management Fees Direct $				
46.			Management Fees Indirect $				
47.			Other - Direct $	29,291	29,291		
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)***		$	1,265,505	1,265,505		

*** 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	5j	Medical Equipment Rental	$ 2,284		
20	5j	Physical Therapy Equipment Rental	$ 26,722		
20	5j	Nursing Admin Small Equipment Purchase	$ 2,713		
20	5j	Medical Supplies % of Nursing/Incontinent/Wound Care Supplies	$ 53,057		
20	5j	OT Small Equipment Purchase	$ 963		
20	5j	PT Small Equipment Purchase	$ 698		
20	5j	Specialty Mattresses	$ 25,689		
Total Other Ancillary Costs			$ 112,126	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
		To include moveable depreciation expense at prior owner basis which	$ (17,244)		
		were purchased by new owner			
Total Excess Movable Equipment Depreciation			$ (17,244)	$ -	$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	6f	Minor Decorating	$ 4,312		
22	6f	Plant Purchased Services	$ 3,449		
29B		Outpatient Therapy Rent Allocation	$ 1,178		
29B		Outpatient Therapy Insurance Allocation	$ 46		
29B		Outpatient Therapy A&G Allocation	$ 407		
29B		Outpatient Therapy Indirect Allocation	$ 294		
Total Other Property Adjustments			$ 9,686	$ -	$ -

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)

Total Other Adjustments			$ -	$ -	$ -

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	12d	Interest Expense	$ 4,252		
20	5J	Cable TV	$ 15,029		
30	IV8	Misc. Income	$ 8,428		
30	IV5	Interest Income	$ 1,582		
Total Other Adjustments			$ 29,291	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			$ -	$ -	$ -

Estimated Overhead on Outpatient Therapy

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

Outpatient Treatments - per client questionnaire	
PT	225
ST	106
OT	93
Total Outpatient Treatments	424
Total Treatments - Page 9 of Cost Report	
PT	5,530
ST	502
OT	2,717
Total Therapy Treatments	8,749
Outpatient Treatments %	0.048462681
Outpatient Allocation of Therapy Space %	0.000933947
Expense Item:	
Heat	125,640
Light & Power	131,886
Repairs & Maintenance	39,386
Other Repairs Maintenance	139,395
Sub-total	436,307
Outpatient Allocation of Therapy Space %	0.000933947
Unallowable A&G Expense	407
Housekeeping Salaries	0
Other Housekeeping Expense	314,427
Sub-Total	314,427
Outpatient Allocation of Therapy Space %	0.000933947
Unallowable Indirect Expense	294
Property & Umbrella Insurances (Excluding Auto)	49,323
Outpatient Allocation of Therapy Space %	0.000933947
Unallowable Capital Expense	46
Rent Expense	1,261,484
Outpatient Allocation of Therapy Space %	0.000933947
Unallowable Rent Expense	1,178

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
New Milford Rehabilitation, LLC	2207C	9/30/2019	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	13,016,581	13,016,581		
b. Medicaid Room and Board Contractual Allowance **	$	(6,715,973)	(6,715,973)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	2,970,489	2,970,489		
b. Medicare Room and Board Contractual Allowance **	$	1,477,177	1,477,177		
4. a. Private-Pay Residents and Other	$	5,144,169	5,144,169		
b. Private-Pay Room and Board Contractual Allowance **	$	(419,152)	(419,152)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	218,936	218,936		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(217,440)	(217,440)		
c. Prescription Drugs - Non-Medicare	$	147,710	147,710		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(132,299)	(132,299)		
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	1,062,726	1,062,726		
b. Physical Therapy - Medicare Contractual Allowance **	$	(975,191)	(975,191)		
c. Physical Therapy - Non-Medicare	$	339,770	339,770		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(285,654)	(285,654)		
4. a. Speech Therapy - Medicare	$	152,400	152,400		
b. Speech Therapy - Medicare Contractual Allowance **	$	(134,007)	(134,007)		
c. Speech Therapy - Non-Medicare	$	78,905	78,905		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(56,989)	(56,989)		
5. a. Occupational Therapy - Medicare	$	951,355	951,355		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(909,482)	(909,482)		
c. Occupational Therapy - Non-Medicare	$	258,584	258,584		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(227,181)	(227,181)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	9,125	9,125		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	15,754,559	15,754,559		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	613	613		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	1,582	1,582		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	45,247	45,247		
V. Total Other Revenue (1 thru 8)	$	47,442	47,442		
VI. Total All Revenue (III +V)	$	15,802,001	15,802,001		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30 / 6a	Oxygen Medicare A	$ 2,213		
30 / 6a	X-Ray Medicare A	$ 14,298		
30 / 6a	LAB Medicare A	$ 43,628		
30 / 6a	Less: Contractual Adjustment	$ (60,139)		
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30 / 6b	LAB EverCare	$ 11,529		
30 / 6b	Oxygen Managed Care	$ 464		
30 / 6b	X-Ray Managed Care	$ 5,362		
30 / 6b	LAB Managed Care	$ 11,135		
30 / 6b	Less: Contractual Adjustment	$ (19,365)		
Total Other Resident Revenue		$ 9,125	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30/ IV5	Interest Income		$ 1,582		
Total Interest Income			$ 1,582	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 / 6b	Miscellaneous Income	$ 8,428		
30 / 6b	Optum Program Revenue	$ 36,819		
Total Other Revenue		$ 45,247	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2019	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 703,963
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 2,480,022
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 705,549
4 Inventories				$
5. Prepaid Expenses				$ 55,833
a. Expenses		4,431		
b. Insurance		39,038		
c. Sewer		8,299		
d. See Schedule		4,065		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 49,215
Patient Funds Held in Trust		49,215		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 3,994,582
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost	893,023		$ 837,824
	Accum. Depreciation	55,199	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	107,876		$ 61,915
	Accum. Depreciation	45,961	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 23,241
Construction on Progress		23,241		
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 922,980

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	A5d	Taxes	$ 4,065
Total Prepaid Expenses			$ 4,065

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

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

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

Schedule of Other Current Liabilities (Itemize) Page 33 Line A12

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

Schedule of Other Long-Term Liabilities (Itemize) Page 34 Line B4

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2019	32	37

Account				Amount
			Total Brought Forward:	$ 4,917,562
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*)				$ 12,810
Deposits		12,810		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 12,810
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 4,930,372

* 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
New Milford Rehabilitation, LLC	2207C	9/30/2019	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 1,243,869
2. Notes Payable (*itemize*)	$
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*)	$ 427,927
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$ 1,813
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*)	$ 693,077

Deferred Revenue	49,000	Accrued Provider User Fe	210,704
Resident Trust	49,215		
Accrued Operating Expenses	144,951		
Accrued Liabilities Other	239,207	See Schedule	

A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 2,366,686

* 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
New Milford Rehabilitation, LLC	2207C	9/30/2019	34	37

Account	Amount
Total Brought Forward:	2,366,686
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$ 128,961

Name and Address of Lender	Amount	Loan Date
NMHC Realty LLC	128,961	Various

4. Other Long-Term Liabilities (*itemize*)	$
See Schedule	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 128,961
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 2,495,647

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

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	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 (*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	$
B.	**Net Worth**	
	1. Owner's Capital	$ 1,298,867
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 557,221
	6. Gain or Loss for Period 10/1/2018 thru 9/30/2019	$ 578,637
	7. Total Net Worth	$ 2,434,725
C.	***Total Reserves and Net Worth***	$ 2,434,725
D.	***Total Liabilities, Reserves, and Net Worth***	$ 4,930,372

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2019	36	37

Account				Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2018				$ 1,298,867
B. Total Revenue (*From Statement of Revenue Page 30*)				$ 15,802,001
C. Total Expenditures (*From Statement of Expenditures Page 27*)				$ 15,223,364
D. Net Income or Deficit				$ 578,637
E. Balance				$ 1,877,504
F. Additions				
1. Additional Capital Contributed (*itemize*)				
Equity Contributions			647,221	
2. Other (*itemize*)				
F-3. Total Additions				$ 647,221
G. Deductions				
1. Drawings of Owners/Operators/Partners (*Specify*)				$ 90,000
Name and Address (*No., City, State, Zip*)		Title	Amount	
Distribution			90,000	
2. Other Withdrawings *(Specify)*				$
Purpose		Amount		
3. Total Deductions				$ 90,000
H. ***Balance at End of Period***	09/30/19			$ 2,434,725

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2019	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
Blum, Shapiro & Company, P.C.		2/13/2020

Printed Name of Preparer	
Blum, Shapiro & Company, P.C.	
Addres Address	Phone Number
29 S Main Street, West Hartford, CT	860-561-4000
Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Jonathan Fink	860-561-4000
Contact Email Address	
JFINK@blumshapiro.com	