State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2020

Name of Facility (as licensed) Montowese Health & Rehabilitation Center		
Address (No. & Street, City, State, Zip Code) 163 Quinnipiac Avenue, North Haven, CT 06473		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2442			075017

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	10157		

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2020	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Montowese Health & Rehabilitation Center [facility name], for the cost report period beginning October 1, 2019 and ending September 30, 2020, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Donna C. Orefice			Printed Name (Owner) Lawrence Santilli	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Montowese Health & Rehabilitation Center	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 163 Quinnipiac Avenue, North Haven, CT 06473				
Report Prepared By Athena Health Care Associates	Phone Number (860) 751-3900		Date	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$				
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$				
5. All other wages paid	$				
6. ***Total Wages Paid***	$				
7. Total salaries paid	$				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-624-3303	9/30/2020	2	37

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

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2442			075017

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Donna C. Orefice	00167

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

Name	License No.:
N/A	

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
Montowese Health & Rehabiliation Center	163 Quinnipiac Avenue, North Haven, CT	CT

Name of Partners/Members	Business Address	Title	% Owned
Lawrence G Santilli	135 South Rd Farmington, CT 06032	President	0.63

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
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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

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

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2020	3B	37

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Montowese Landlord LLC	135 South Rd, Farmington, CT 06032	○	⊙		Lease of Property	Pg 22 L9	923,866	923,866
Athena Health Care Assoc 401k Plan	135 South Rd, Farmington, CT 06032	○	⊙		Facility participates in common 401k plan			
Athena Health Care System	135 South Rd, Farmington, CT 06032	⊙	○	<50%	see attached		561,528	299,004
Procare Pharmacy	111 Executive Blvd, Farmingdale, NY 11735	⊙	○	>50%	Pharmacy Services	pg 20 5a2, 5b,	1,085,025	1,085,025
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

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

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

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

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

N/A

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

N/A

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
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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
Xerox, PO Box 202882, Dallas, TX 75320-2882	○	⊙	Copier	01/31/18	36	22,178	22,178
Pitney Bowes, PO Box 371887, Pittsburgh, PA 15250	○	⊙	Mail Machine	01/31/18	63	2,004	2,138
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
						Total ***	24,316

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No

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

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
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The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Marcum, LLP	185 Asylum St, 17th Floor, Hartford, CT 06103
2 Bedford Cost Segregation Energy R&D	19 Kilton Rd, Suite 100, Bedford, NH 03110
3	
4	

Services Provided by This Firm (*describe fully*)

1	Audit Fee	$ 22,500
2	Cost Report	$ 2,700
3	Tax returns	$ 5,150
4		$
		Charge for Services Provided $ 30,350

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
⊙ Yes ○ No Pg 15, Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Murtha Cullina	203-772-7700
2 Timothy Wall	203-265-7173
3 Goldman, Gruder & Woods	203-899-8900
4 Treasurer State of CT	
5	

Address (*No. & Street, City, State, Zip Code*)
1 265 Church Street, New Haven, CT 06510
2 PO Box 297, Wallingford, CT 06492
3 200 Connecticut Avenue, Norwalk, CT 06854
4
5

Services Provided by This Firm (*describe fully*)

1	Audit Letter: allow	$ 747
2	Conservatorship:Disallow	$ 237
3	collections:Disallow	$ 9,292
4	Conservatorship:Disallow	$ 1,541
5	Conservatorship:Disallow	$ 10,316
		Charge for Services Provided $ 22,133

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
⊙ Yes ○ No Pg 15, Line 1e

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Schedule of Resident Statistics

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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	120	120			120	120						
B. On last day of THIS report period	120	120							120	120		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	118	118			118	118						
B. As of midnight of THIS report period	90	90							90	90		
3. Total Number of Days Care Provided During Period												
A. Medicare	15,345	15,345			12,094	12,094			3,251	3,251		
B. Medicaid (Conn.)	18,503	18,503			14,419	14,419			4,084	4,084		
C. Medicaid (other states)												
D. Private Pay	1,559	1,559			914	914			645	645		
E. State SSI for RCH												
F. Other (Specify)	1,190	1,190			946	946			244	244		
G. Total Care Days During Period (3A thru F)	36,597	36,597			28,373	28,373			8,224	8,224		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	23	23			23	23						
B. Other Bed Reserve Days	26	26			20	20			6	6		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	36,646	36,646			28,416	28,416			8,230	8,230		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	20	43		6		21		
Per Diem Rate								
a. One bed rm.	575.91	251.25		600.00		426.41		
b. Two bed rms.	575.91	251.25		550.00		426.41		
c. Three or more bed rms.	575.91	251.25		500.00		426.41		

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	3,861	3,861		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	6,591	6,591		
2. Restorative Treatments				
C. Other	36,608	36,608		
D. ***Total Physical Therapy Treatments***	47,060	47,060		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	319	319		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	388	388		
2. Restorative Treatments				
C. Other	2,324	2,324		
D. ***Total Speech Therapy Treatments***	3,031	3,031		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	3,449	3,449		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	5,582	5,582		
2. Restorative Treatments				
C. Other	35,549	35,549		
D. ***Total Occupational Therapy Treatments***	44,580	44,580		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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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)	184,844	1,707				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	367,761	12,172				
5. Dietary Service						
a. Head Dietitian	47,590	1,206				
b. Food Service Supervisor	76,354	1,960				
c. Dietary Workers	474,204	25,271				
6. Housekeeping Service						
a. Head Housekeeper	87,606	2,359				
b. Other Housekeeping Workers	390,494	21,519				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	61,803	1,788				
b. Other Maintenance Workers	103,694	4,117				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	117,429	7,196				
9. Barber and Beautician Services						
10. Protective Services	21,787	1,501				
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	258,914	3,898				
b. RN						
1. Direct Care	1,120,512	20,249				
2. Administrative**	1,220,418	33,389				
c. LPN						
1. Direct Care	1,352,775	36,044				
2. Administrative**						
d. Aides and Attendants	1,793,193	78,163				
e. Physical Therapists	1,169,559	26,185				
f. Speech Therapists	123,946	2,336				
g. Occupational Therapists	789,405	18,405				
h. Recreation Workers	134,262	6,418				
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	441,571	29,186				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	10,338,121	335,069				

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.
** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.
*** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

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

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

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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
N/A										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
N/A										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Stella Akopyants	184,844			Health & Life Insurance, Payroll Taxes	Day to day operations if the nursing home facility	1,707	A2			
10/1/19-8/14/20										
Section IV - Assistant Administrators										
Donna C. Orefice				Health & Life Insurance, Payroll Taxes	Day to day operations if the nursing home facility		A2			
08/15/20-9/30/20										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2020	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	3,240	60				
3. Pharmacist	9,042	51				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	77,000	159				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	521	10				
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	5,355	30				
b. Other	79	2				
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	36,720	1,047				
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	131,957	1,359				

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2020	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Dr. Anuruddha Walaliyadda, 12 Cooke Road, Wallingford, CT 06492	Physician-Medical Director	○	⊙	
Dr. Dharini Sun, 2690 Whitey Avenue, Hamden, CT 06518	Physician-Medical Director	○	⊙	
Arrhythmia Consultants of CT, 1000 Asylum Ave #3206, Hartford, CT 06105	Physician	○	⊙	
Griffin Hospital, 130 Division St., Derby, CT 06418	Physician	○	⊙	
Healthdrive Eye Care Group, 101 Centerpoint Drive Ste 215, Middletown, CT 06457	Physician	○	⊙	
Masstex Imaging, LLC, 3 Electronics Ave, Ste 201, Danvers, MA 01923	Speech Therapy	○	⊙	
SDX Dysphagia Experts, 21 Waterville Rd, Avon, CT 06001	Speech Therapy	○	⊙	
Healthdrive Dental Group, 888 Worcester St., Wllesley, MA 02482	Dentist	○	⊙	
Procare LTC Pharmacy, 110 Bi-County Blvd, Ste 121, Farmingdale, NY 11735	Pharmacist	⊙	○	Common Owners: Minority Interest
Yale New Haven Hospital, P.O. Box 780406, Philadelphia, PA 19178	Physician	○	⊙	
Celtic Consulting LLC, 507 East Main Street, Suite 308, Torrington, CT 06790	Consulting Services	○	⊙	
Athena Health Care Associates, Inc, 135 South Road, Farmington, CT	MDS Fill in	⊙	○	Common Owners
Quest Diagnostic, 3404 Collection Center Drive, Chicago, IL 60693	Physician	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2020	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	262,524	262,524		
2. Disability Insurance	$				
3. Unemployment Insurance	$	109,997	109,997		
4. Social Security (F.I.C.A.)	$	760,887	760,887		
5. Health Insurance	$	695,477	695,477		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	69,251	69,251		
(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*	$	136,001	136,001		
d. Accounting and Auditing	$	30,350	30,350		
e. Legal (*Services should be fully described on Page 7)*	$	22,133	22,133		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	60,903	60,903		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	8,850	8,850		
2. Cellular Phones	$	2,218	2,218		
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*	$	2,459	2,459		
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	447,747	447,747		
Subtotal	$	2,608,797	2,608,797		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2020	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,608,797	2,608,797		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	10,955	10,955		
3. Gifts to Staff and Residents	$	22,300	22,300		
4. Employee Travel	$	4,768	4,768		
5. Education Expenses Related to Seminars and Conventions	$	14,835	14,835		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	23,982	23,982		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	1,226	1,226		
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)***	$				
7. Postage	$	4,194	4,194		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	9,899	9,899		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$				
13. Other (*Specify*) See Attached Schedule	$	172,091	172,091		
C-14 Total Administrative & General Expenditures	$	2,873,047	2,873,047		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	$ 1,226		
Total Other Advertising	$ 1,226	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
AHCA	$ 1,200		
CAHCF Dues	$ 8,699		
Total Dues	$ 9,899	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Penalties-Cival Money Penalty-IRS penalty Citation #2019-047	$ 25,358		
Licenses	$ 2,470		
Bank Charges	$ 26,045		
Payroll Processing Fees	$ 27,379		
Employee Physicals/Background Checks	$ 8,279		
Data Processing/ Software Maint. Fees	$ 67,017		
Facilities Comp Fire Consulting Fees	$ 15,363		
Credit Card Fees	$ 180		
Total Other Administrative and General	$ 172,091	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
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Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Athena Health Care Associates Inc., 135 South Road, Farmington, CT 06032		Contract Attached to a Prior Year	See Below
Allocation of the Above		Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, line 12

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

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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
Montowese Health & Rehabilitation Center	2442	9/30/2020	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	329,803	329,803		
2. Non-Food Supplies	$	29,064	29,064		
3. Other (*Specify*)_____ Dishes	$	7,211	7,211		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	366,078	366,078		

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
Montowese Health & Rehabilitation Center	2442	9/30/2020	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $	28,623	28,623		
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*) Laundry Supplies	$	4,762	4,762		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	33,385	33,385		

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
Montowese Health & Rehabilitation Center	2442	9/30/2020	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.	$	147,342	147,342		
b. Purchased Services (*by contract other than through Management Services*)	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	147,342	147,342		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Procare Pharmacy		$	957,212	957,212		
b. Medicine Cabinet Drugs		$	15,751	15,751		
c. Medical and Therapeutic Supplies		$	541,823	541,823		
d. Ambulance/Limousine***		$	14,047	14,047		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	18,780	18,780		
f. X-rays and Related Radiological Procedures***		$	61,150	61,150		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	141,798	141,798		
i. Recreation		$	7,520	7,520		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	180,381	180,381		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	1,938,462	1,938,462		

* 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)
Cable TV	$ 39,250		
Medical Equip Rentals-Medicaid	$ 38,304		
Physical Therapy Supplies	$ 15,559		
Occupational Therapy Supplies	$ 693		
Oxygen Equipment Rentals	$ 53,605		
Medical Equip Rentals-Other	$ 32,970		
Total Other Resident Care	$ 180,381	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2020	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
CWPM, LLC	25 Norton Place, Plainville, CT 06062	○	⊙		Rubbish Removal	36,522			22	6f
Procare LTC Pharmacy	111 Excutive Blvd Farmingdale NY 11735	⊙	○	Common Owners: Minority Interest	Pharmacy Services	871,775			20	5A2 &
ADP	PO Box 842875, Boston, MA 02284-2875	○	⊙		Payroll Processing	5,212			16	m13
Executive Landscaping	PO Box 185790, Hamden, CT 06518	○	⊙		Landscaping and Snow Removal Services	26,048			22	6f
Advantage Maintenance	15 Lunar Drive, Woodbridge, CT 06525	○	⊙		Kitchen Services	1,118			18	2b
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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).

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Groundskeeping	$ 30,834		
Rubbish Removal	$ 36,522		
Snow Removal	$ 11,525		
Supplies	$ 60,261		
Total Other Repairs and Maintenance	$ 139,142	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health & Rehabilitation Center	2442	9/30/2020	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	138,392	138,392		
b. Heat	$	55,888	55,888		
c. Light & Power	$	138,902	138,902		
d. Water	$	49,145	49,145		
e. Equipment Lease (*Provide detail on page 6*)	$	24,316	24,316		
f. Other (*itemize*)	$	139,142	139,142		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	545,785	545,785		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$				
d. Movable Equipment	$	150,905	150,905		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	150,905	150,905		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$	611,745	611,745		
b. Mortgage Expense	$				
c. Leasehold Improvements	$	15,970	15,970		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	627,715	627,715		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	923,866	923,866		
10. Property Taxes					
a. Real estate taxes paid by owner	$	151,736	151,736		
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	14,912	14,912		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,869,134	1,869,134		

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

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2020	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								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			9	2019	728,366		728,366	222,686	S/L	Various	150,236	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2020	5,891		5,891		S/L	Various	669	
D-3. Subtotal												150,905
E. ***Total Depreciation***												150,905

Schedule of Land Improvements Acquired during this report period

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

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

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

Schedule of Building Improvements Acquired during this report period

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

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

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

Schedule of Non-Movable Equipment Acquired during this report peri

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

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

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

Schedule of Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
7/31/2020	Curtains	$ 2,178	5	$ 218	
7/31/2020	Tablets	$ 1,194	3	$ 199	
8/31/2020	Cubicle Curtain	341	5	34	
9/30/2020	6 Track Curtain	2178	5	218	
Total additions for Movable Equipmen		$ 5,891		$ 669	*
Deletions:					
Total deletions for Movable Equipmen		$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
12/31/2019	Replaced Blower Motor	$ 1,426	20	$ 36	
4/30/2020	Repair/Replaced Multiple Air duct Mechanical	$ 14,223	10	$ 711	
5/31/2020	Replace Fridge Motor	1368	20	34	
6/30/2020	Compressor	4987	12	208	
6/30/2020	Hollow Metal Doors	4859	20	121	
8/31/2020	Wood Door	1484	15	49	
8/31/2020	4 New Door Operators	28269	15	942	
Total additions for Leasehold Improvemer		$ 56,616		$ 2,101	*
Deletions:					
Total deletions for Leasehold Improvemer		$ -		$ -	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2020	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.	Jan	2018	10 Years	6,059,160	927,701	S/L		611,745	
2.									
3.									
A-4. Subtotal									611,745
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	9	2019	Various	144,553	13,405	S/L	Variou	13,869	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2020	Various	56,616		S/L	Variou	2,101	
C-4. Subtotal									15,970
D. ***Total Amortization***									627,715

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation C	2442	9/30/2020	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	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	120
6. Square Footage	
7. Acquisition Cost	
a. Land	200,000
b. Building	9,020,872

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Conventional			
b. Date Mortgage Obtained	01/25/18			
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	12,800,000			
f. Principal balance outstanding as of _____	12,355,000			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health & Rehabilitation C	2442	9/30/2020	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
Montowese Health & Rehabilitation	2442	9/30/2020	27	37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				
12. C. Movable Equipment				
1. Automotive Equipment $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
2. Other (*Specify*) $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
B. Item / Rate / Amount				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $				
12. D. Other Interest Expense (*Specify*) $	16,212	16,212		
Vendor Interest				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	16,212	16,212		
14. Insurance				
a. Insurance on Property (buildings only) $	84,975	84,975		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $				
2. Fire and Extended Coverage $				
3. Other (*Specify*) $				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	84,975	84,975		
15. ***Total All Expenditures (A-13 thru C-14)*** $	18,344,498	18,344,498		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health & Rehabilitation Center	2442	9/30/2020	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 $	489,405	489,405		
4.			Other - See attached Schedule $	1,390	1,390		
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $	521	521		
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $	136,001	136,001		
10.			Accounting $	21,386	21,386		
10a.			Legal $				
11.			Telephone $				
12.			Cellular Telephone $	2,938	2,938		
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $	22,300	22,300		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $	8,725	8,725		
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.			Unallowable Advertising * $	1,226	1,226		
19.			Income Tax / Corporate Business Tax $	2,459	2,459		
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $	(169,148)	(169,148)		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	72,833	72,833		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $	2,474	2,474		
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) $	592,510	592,510		

* 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)
		Marketing Salary & Benefits	$ 1,390		
Total Other Salaries Adjustment			$ 1,390	$ -	$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M13	Bank Charges	$ 26,045		
16	M13	Facilities Comp Fire Consulting Fees	$ 15,363		
30	IV8	Property Insurance Claim	$ 5,887		
16	M13	Penalties-Cival Money Penalty-IRS penalty Citation #2019-047	$25,358		
16	M13	Credit Card Fees	$180		
Total Other A&G Adjustments			$ 72,833	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2020	29	37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	592,510	592,510		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs $	957,212	957,212		
28.			Ambulance/Limousine $	14,047	14,047		
29.			X-rays, etc $	61,150	61,150		
30.			Laboratory $	141,798	141,798		
31.			Medical Supplies $	16,086	16,086		
32.			Oxygen (non emergency) $	18,780	18,780		
33.			Occupational Therapy $	693	693		
34.			Other - See Attached Schedule $	44,050	44,050		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $	65,030	65,030		
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Other - Indirect $	38,890	38,890		
43.			Interest Income on Account Rec. $	231	231		
44.			Other - Miscellaneous Administrative $				
45.			Management Fees Direct $	(46,161)	(46,161)		
46.			Management Fees Indirect $	(41,006)	(41,006)		
47.			Other - Direct $				
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
49.			***Total Amount of Decrease (Items 1 - 48)*** $	1,863,310	1,863,310		

*** 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 - Other	$ 32,970		
20	5b	Ebox	$ 4,086		
20	5c	Nursing Supply Rebate	$ 6,994		
Total Other Ancillary Costs			$ 44,050	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Equipment Depreciation Carry Forward Adjustment	$ 65,030		
Total Excess Movable Equipment Depreciation			$ 65,030	$ -	$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Radio and Television Revenue	$ 38,890		
Total Other Adjustments			$ 38,890	$ -	$ -

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)
Total Other Adjustments			$ -	$ -	$ -

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Cent	2442	9/30/2020	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	8,903,410	8,903,410		
b. Medicaid Room and Board Contractual Allowance **	$	(4,166,521)	(4,166,521)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	4,792,830	4,792,830		
b. Medicare Room and Board Contractual Allowance **	$	1,184,596	1,184,596		
4. a. Private-Pay Residents and Other	$	4,182,176	4,182,176		
b. Private-Pay Room and Board Contractual Allowance **	$	71,636	71,636		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	549,228	549,228		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(549,228)	(549,228)		
c. Prescription Drugs - Non-Medicare	$	506,169	506,169		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(506,169)	(506,169)		
2. a. Medical Supplies - Medicare	$	1,360	1,360		
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$	1,604	1,604		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(1,604)	(1,604)		
3. a. Physical Therapy - Medicare	$	1,309,014	1,309,014		
b. Physical Therapy - Medicare Contractual Allowance **	$	(1,187,257)	(1,187,257)		
c. Physical Therapy - Non-Medicare	$	1,123,020	1,123,020		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(1,123,020)	(1,123,020)		
4. a. Speech Therapy - Medicare	$	219,850	219,850		
b. Speech Therapy - Medicare Contractual Allowance **	$	(203,644)	(203,644)		
c. Speech Therapy - Non-Medicare	$	165,730	165,730		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(165,730)	(165,730)		
5. a. Occupational Therapy - Medicare	$	1,250,716	1,250,716		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(1,151,869)	(1,151,869)		
c. Occupational Therapy - Non-Medicare	$	1,037,735	1,037,735		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(1,037,735)	(1,037,735)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	273,294	273,294		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	15,479,591	15,479,591		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	231	231		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	26,758	26,758		
V. Total Other Revenue (1 thru 8)	$	26,989	26,989		
VI. Total All Revenue (III +V)	$	15,506,580	15,506,580		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
N/A	Misc Revenue from CRF Funds	$ 273,294		
Total Other Resident Revenue		$ 273,294	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Pg 30 IV5	Interest on A/R		$ 231		
Total Interest Income			$ 231	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Property Damage Insurance Claim Settlement	$ 5,887		
	Bad Debt Recovery	$ 13,877		
	Medline Rebate	$ 6,994		
Total Other Revenue		$ 26,758	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Ce	2442	9/30/2020	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 352,834
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,549,913
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ (922,869)
4 Inventories				$ 30,381
5. Prepaid Expenses				$ 508,991
a. Prepaid Insurance		106,067		
b. Prepaid Health Insurance		154,372		
c. Preapid Tax, Rent, and Other		248,552		
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$ (1,250,000)
8. Other Current Assets (*itemize*)				$ (30)
AR Exchange		(30)		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 269,220
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost			$
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	201,169		$ 171,794
	Accum. Depreciation	29,375	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	246,187		$ (127,404)
	Accum. Depreciation	373,591	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 513,614
See Schedule		513,614		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 558,004

* 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	
Total Prepaid Expenses			$ -

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	
		Moveable Equipment Carryforward	$ 488,071
		Project Development	$ 25,543
Total Other Other Fixed Assets (Itemize)			$ 513,614

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
Montowese Health & Rehabilitation Ce	2442	9/30/2020	32	37

Account				Amount
		Total Brought Forward:	$	827,224
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	6,059,160		
	Accum. Depreciation	1,539,446 Net	$	4,519,714
4. Goodwill (Purchased Only)			$	(33,583)
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*)			$	160,343
Start Up Costs		160,343		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)			$	4,646,474
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$	5,473,698

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2020	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 2,025,259
2. Notes Payable (*itemize*)					$ 3,208,371
Due to Related Party	3,208,371				
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*)					$ 502,608
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 339,930
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*)					$ (1,250,408)
Due to Affiliates	(1,471,311)	Acc'd Health Insurance	(4,562)		
Acc'd Operating Expenses	(92,047)	Due to/From Related Par	(3,105)		
Acc'd Expense-Sales Tax	524				
Provider Taxes Due	320,093	See Schedule			
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 4,825,760

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2020	34	37

Account	Amount
Total Brought Forward:	4,825,760
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*)	$ 3,154,887

Name and Address of Lender	Amount	Loan Date
Mckesson	(35,094)	
Due to Partnership	3,189,981	

4. Other Long-Term Liabilities (*itemize*)	$
See Schedule	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 3,154,887
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 7,980,647

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Ce	2442	9/30/2020	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*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	$
	2. Capital Stock	$
	3. Paid-in Surplus	$ 3,375,000
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (3,044,031)
	6. Gain or Loss for Period 10/1/2019 thru 9/30/2020	$ (2,837,918)
	7. Total Net Worth	$ (2,506,949)
C.	***Total Reserves and Net Worth***	$ (2,506,949)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 5,473,698

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Cen	2442	9/30/2020	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2019			$ 1,766,974
B.	Total Revenue (*From Statement of Revenue Page 30*)			$
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$
D.	Net Income or Deficit			$
E.	Balance			$
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Health Insurance		(210,249)	
	2019 AJE-Amort Exp		(611,745)	
	Prior year expesne Adjustment (hskpg/O2/lab/ver		42,708	
			(656,719)	
	2. Other (*itemize*)			
F-3.	Total Additions			$ (1,436,005)
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period***	09/30/20		$ (1,436,005)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2020	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. 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

Printed Name of Preparer
Athena Health Care Associates Inc.

Addres Address	Phone Number
135 South Road, Farmington, CT 06032	(860) 751-3900

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Kasie Lester	(860) 751-3900

Contact Email Address
Klester@athenahealthcare.com