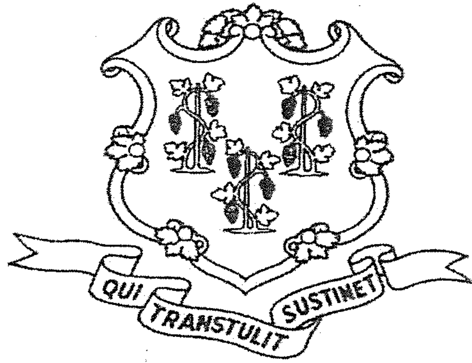
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2018

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 1/25/2018	Report for Year Ending 9/30/2018	

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

Medicaid Provider Numbers:	CCNH 000010157	RHNS	ICF-IID

For Department Use Only

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

Table of Contents

	General Information - Administrator's/Owner's Certification	1
	General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
	General Information and Questionnaire - Type of Facility - Organization Structure	2
	General Information and Questionnaire - Partners/Members	3
	General Information and Questionnaire - Corporate Owners	3A
	General Information and Questionnaire - Individual Proprietorship	3B
	General Information and Questionnaire - Related Parties	4
	General Information and Questionnaire - Basis for Allocation of Costs	5
	General Information and Questionnaire - Leases	6
	General Information and Questionnaire - Accounting Basis	7
	Schedule of Resident Statistics	8
	Schedule of Resident Statistics (Cont'd)	9
A.	Report of Expenditures - Salaries & Wages	10
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B.	Report of Expenditures - Professional Fees	13
	Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C.	Expenditures Other than Salaries - Administrative and General	15
C.	Expenditures Other than Salaries (Cont'd) - Administrative and General	16
	Schedule C-1 - Management Services	17
C.	Expenditures Other than Salaries (Cont'd) - Dietary	18
C.	Expenditures Other than Salaries (Cont'd) - Laundry	19
C.	Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
	Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C.	Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
	Depreciation Schedule	23
	Amortization Schedule	24
C.	Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C.	Expenditures Other than Salaries (Cont'd) - Interest	26
C.	Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D.	Adjustments to Statement of Expenditures	28
D.	Adjustments to Statement of Expenditures (Cont'd)	29
F.	Statement of Revenue	30
G.	Balance Sheet	31
G.	Balance Sheet (Cont'd)	32
G.	Balance Sheet (Cont'd)	33
G.	Balance Sheet (Cont'd)	34
G.	Balance Sheet (Cont'd) - Reserves and Net Worth	35
H.	Changes in Total Net Worth	36
I.	Preparer's/Reviewer's Certification	37

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2018	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 January 25, 2018 and ending September 30, 2018, 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
S. Akopyants		2/4/19.		2/4/19
Printed Name (Administrator) Stella Akopyants			Printed Name (Owner) Lawrence Santilli	
Subscribed and Sworn to before me:	State of CT	Date 2/4/19	Signed (Notary Public) PAT HYJEK NOTARY PUBLIC MY COMMISSION EXPIRES	Comm. Expires 1/1/2020
Address of Notary Public 484 Farmington Hartford CT 06105				

(Notary Seal)

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

Data Required for Real Wage Adjustment				Page 1A	of 37
Name of Facility Montowese Health & Rehabilitation Center		Period Covered:		From 1/25/2018	To 9/30/2018
Address of Facility 163 Quinnipiac Avenue, North Haven, CT 06473					
Report Prepared By Athena Health Care Associates, Inc		Phone Number (860) 751-3900		Date 2/14/2019	

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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-2 Rev. 10/2005

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-624-3303	9/30/2018	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.

Facility changed ownership effective 1/25/18

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
John Sweeney		001459

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

Name	License No.:
Not Applicable	

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3 Rev. 10/2005

General Information and Questionnaire
Partners/Members

Name of Facility Montowese Health & Rehabilitation Center	License No. 2442	Report for Year Ended 9/30/2018	Page 3 of 37

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	63.00%

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3A Rev. 10/2005

General Information and Questionnaire
Corporate Owners

Name of Facility Montowese Health & Rehabilitation Center	License No. 2442	Report for Year Ended 9/30/2018	Page 3A of 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

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Names of Stockholders Owning at Least 10% of Shares			
None other than listed above			

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3B Rev. 10/2005

General Information and Questionnaire
Individual Proprietorship

Name of Facility Montowese Health & Rehabilitation Center	License No. 2442	Report for Year Ended 9/30/2018	Page 3B	of 37
If this facility is owned or operated as an individual proprietorship, provide the following information:				
Owner(s) of Facility				

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2018	4	37

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	408,217	408,217
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			
Athena Captive	135 South Rd, Farmington, CT 06032	○	⊙		Workers Comp Captive	Pg 15, 1a1	178,455	178,455
Athena Health Care Insurance	135 South Rd, Farmington, CT 06032	○	⊙		Self Insured Employee Health Insurance	Pg 15, 1a5	725,079	725,079
Procare Pharmacy	111 Executive Blvd, Farmingdale, NY 11735	⊙	○	>50%	Pharmacy Services	pg 20 5a2, 5b,	668,652	668,652
		○	○					
		○	⊙					
		○	○					

* Use additional sheets if necessary.
** Provide the percentage amount of revenue received from non-related parties.

Montowese Health & Rehabiliation
RELATED PARTIES QUESTIONNAIRE
PAGE 4

FACILITY NAME	ADDRESS	Also Provided Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Costs Reported	Actual Cost to the Related Party
		Yes	No	%**				
Athena Health Care	135 South Road Farmington, CT 06032	X		>50%	Legal, Management Fees, Help Wanted, gifts to staff, Health Insurance, Employee Relations, Business Promotion Lobbying, Payroll Processing Fees, Data Processing Fees, Repairs & Maintenance	Pg 15 ln 1e; Pg 17; Pg 16 Ln 1g, l3, l5, m3, m7, m8, m13 Pg 22 Ln 6a;	$376,088	$134,989

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2018	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.

Not Applicable

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

Not Applicable

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.

0 0

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-6 Rev. 9/2002

General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2018	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
Xerox, PO Box 202882, Dallas, TX 75320-2882	○	⊙	Copier	01/31/18	36	19,781	13,187
Pitney Bowes, PO Box 371887, Pittsburgh, PA 15250	○	⊙	Mail Machine	01/31/18	63	2,131	1,066
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
						Total ***	14,253

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.

ORIGINAL

xerox

ASSIGNMENT, ASSUMPTION AND CONSENT AGREEMENT

This ASSIGNMENT, ASSUMPTION AND CONSENT AGREEMENT ("Assignment") is entered into by and between **ATHENA HEALTH CARE ASSOCIATES** ("Assignor"), **MONTOWESE HEALTH AND REHABILITATION CENTER, INC.** ("Assignee") and **Xerox Financial Services, LLC** ("XFS"), (collectively, the "Parties"), as of **4/10/2018** ("Effective Date").

WHEREAS, XFS has entered into one or more Agreements with Assignor (collectively, "Agreement") to provide certain equipment to Assignor, as follows:

Affected contract numbers: 010-0087393-001

WHEREAS, in conjunction with Assignee's acquisition of all or a part of Assignor's business, Assignor desires to assign to Assignee the equipment/software as set forth in Exhibit A ("Equipment/Software") under the Agreement; and

WHEREAS, Assignee has agreed to accept such assignment of the Equipment/Software and Services under the terms and conditions of the Agreement until its expiration and as consistent with the terms and conditions hereof.

NOW, THEREFORE, in consideration of the above and intending to be legally bound, the Parties agree as follows:

1. As of the Effective Date, Assignor assigns to Assignee, and Assignee accepts and assumes, all of Assignor's rights, title and interest in and to the Agreement with respect to the Equipment/Software. Assignor agrees to pay to XFS any relocation costs.
2. Assignor remains liable to XFS for its obligations under the Agreement arising prior to the Effective Date. In addition, in the event of default by Assignee after the Effective Date, Assignor agrees that it remains liable to XFS under the Agreement, and waives presentment for payment, demand, and notice of default.
3. XFS consents to this Assignment but expressly prohibits any further assignment without XFS's prior written consent.
4. In the event that XFS currently maintains either a security interest or title to the equipment specified in the Agreement, Assignee authorizes XFS to execute and/or file any documentation on Assignee's behalf necessary to evidence or perfect such interest.
5. Notices under the terms of the Agreement will continue to be governed by the notice provisions thereof, with Assignee's address as shown on page 2 hereof.
6. This Assignment is assigned the contract **#010-0093702-001**. The parties will reference such number in all amendments and/or notices with each other regarding this obligation.
7. Except as specifically provided herein, all terms and conditions of the Agreement remain in full force and effect. In the event of any conflict between the terms and conditions stated in this Assignment and the terms and conditions of the Agreement, this Assignment governs.
8. This Assignment may be executed in multiple counterparts, which together constitute one Assignment binding on the Parties, notwithstanding that the Parties have not signed the same counterpart.
9. This Assignment may not be amended except in writing signed by the Parties.

ASSIGNOR, ATHENA HEALTH CARE ASSOCIATES

By: Name (Please Print): MALCOLM E. MASON

Signature: [signature]

Title: DIRECTOR of IT

Date: 4/12/18

(July 18th, 2011)

ORIGINAL

Xerox Financial Services LLC
45 Glover Avenue
Norwalk, CT 06856

Cost Per Copy Agreement

Lease Agreement # 87393	Dealer Name: Connecticut Business Systems

LESSEE INFORMATION

Full Legal Name		DBA		
ATHENA HEALTH CARE ASSOCIATES, INC.				
Billing Address		**City**	**State**	**ZIP Code**
135 SOUTH ROAD		FARMINGTON	CT	06032
Phone	**Contact Name**	**Contact Email**	**Lessee PO# (Optional)**	
860-751-3900	Malcolm Mason	MMason@AthenaHealthCare.com		

EQUIPMENT

Quantity	Model and Description	Quantity	Model and Description
	SEE SCHEDULE A		

Equipment Location (If different from Billing Address)
[illegible]

TERM AND PAYMENT	IMAGE TYPE	IMAGES INCLUDED	EXCESS CHARGE	PRINTS INCLUDED	EXCESS CHARGE
Initial Lease Term (in months): 36, plus the Interim Period, if any	B&W	10,000	.004		
	Color	3,000	.04		
Monthly Lease Payment: $ 1,550 plus applicable charges & taxes	Color Level 1			N/A	N/A
	Color Level 2			N/A	N/A
	Color Level 3			N/A	N/A

LESSEE ACCEPTANCE

BY YOUR SIGNATURE BELOW, YOU ACKNOWLEDGE THAT YOU ARE ENTERING INTO A NON-CANCELLABLE LEASE AND THAT YOU HAVE READ AND AGREED TO ALL APPLICABLE TERMS AND CONDITIONS SET FORTH ON PAGES 1 AND 2 OF THIS LEASE.

Authorized Signer	Date	Federal Tax ID # (Required)
X [signature]	12/28/17	82-2458271
Print Name	**Title (Indicate President, Partner, Proprietor, etc.)**	
Malcolm E. Mason	Director of IT Business Intelligence	

LESSOR ACCEPTANCE

Accepted By: Xerox Financial Services LLC	Name and Title	Date
	[signature]	01/30/2018

TERMS & CONDITIONS

1. Definitions. The words "you" and "your" mean the legal entity identified in "Lessee Information" above, and "XFS," "we," "us" "Lessor" and "our" means Xerox Financial Services LLC. "Party" means you or XFS, and "Parties" means both you and XFS. "Dealer" means the entity identified in "Dealer Name" above. "Commencement Date" means the date subsequent to the Inception Date when XFS funds the Dealer and/or other party for the Equipment. "Discount Rate" means a rate equal to the 1-year Treasury Constant Maturity rate as published in the Selected Interest Rates table of the Federal Reserve statistical release H.15(519) or successor publication for the week ending immediately prior to the Inception Date. "Equipment" means the items identified in "Equipment" above and in any attached Equipment schedule, plus any Software (as defined in Section 3 hereof), attachments, accessories, replacements, replacement parts, substitutions, additions and repairs thereto. "Excess Charges" means the applicable excess copies and/or prints charges. "Inception Date" means (a) the date Dealer determines Equipment installed by Dealer is operating satisfactorily and is available for your use, or (b) the date Equipment identified by Dealer as being installable by you is delivered to your premises. "Interim Period" means the period between the Inception Date and the Commencement Date. "Interim Payment" means one thirtieth of the Lease Payment multiplied by the number of days in the Interim Period, plus any applicable Excess Charges. "Lease" means this Cost Per Copy Agreement, including any attached Equipment schedule. "Lease Payment" means the Monthly Lease Payment specified above, which includes the fixed component of maintenance charges payable to Dealer under the Maintenance Agreement, the Excess Charges (unless otherwise agreed by you, Dealer and XFS), and other charges you, Dealer and XFS agree will be invoiced by XFS on a monthly basis, plus Taxes. "Maintenance Agreement" means a separate agreement between you and Dealer for maintenance and support purposes. "Origination Fee" means a one-time fee of $125 billed on your first invoice which you agree to pay, covering the origination, documentation, processing and certain other initial costs for the Lease. "Term" means the Interim Period, together with the Initial Lease Term plus any subsequent renewal or extension terms. "UCC" means the Uniform Commercial Code of the State of Connecticut (C.G.S.A. §§42a-1-101 et seq.).

2. Lease, Payments and Late Payments. You agree and represent all Equipment was selected, configured and negotiated by you based upon your own judgment and has been, or is being, supplied by Dealer. At your request, XFS has acquired, or will acquire, the same to lease to you under this Lease and you agree to lease the same from XFS. The Initial Lease Term, which is indicated above, commences on the Inception Date. You agree to pay XFS the first Lease Payment plus any applicable Interim Payment 30 days after the Commencement Date; each subsequent Lease Payment, which may include charges you, Dealer and XFS agree will be invoiced by us, shall be payable on the same date of each month thereafter, whether or not XFS invoices you. If any payment is not paid in full within 5 days after its due date, you will pay a late charge of the greater of 10% of the amount due or $25, not to exceed the maximum amount permitted by law. For each dishonored or returned payment, you will be assessed the applicable returned item fee, which shall not exceed $35. Restrictive covenants on any method of payment will be ineffective.

3. Equipment and Software. To the extent that the Equipment includes intangible property or associated services such as software licenses, such intangible property shall be referred to as "Software." You acknowledge and agree that that XFS has no right, title or interest in the Software and you will comply throughout the Lease Term with any license and/or other agreement ("Software License") with the supplier of the Software ("Software Supplier"). You are responsible for entering into any required Software License with the Software Supplier no later than the Inception Date. You agree the Equipment is for your lawful business use in the United States (including its possessions and territories), will not be used for personal, household or family purposes, and is not being acquired for resale. You will not attach the Equipment as a fixture to real estate or make any permanent alterations to it.

4. Non-Cancellable Lease. THIS LEASE CANNOT BE CANCELLED OR TERMINATED BY YOU PRIOR TO THE END OF THE INITIAL LEASE TERM. YOUR OBLIGATION TO MAKE ALL LEASE PAYMENTS, AND TO PAY ALL OTHER AMOUNTS DUE OR TO BECOME DUE, IS ABSOLUTE AND UNCONDITIONAL AND NOT SUBJECT TO DELAY, REDUCTION, SET-OFF, DEFENSE, COUNTERCLAIM OR RECOUPMENT FOR ANY REASON WHATSOEVER, IRRESPECTIVE OF THE PERFORMANCE OF THE EQUIPMENT, DEALER, ANY THIRD PARTY OR XFS. Any pursued claim by you against XFS for alleged breach of our obligations hereunder shall be asserted solely in a separate action; provided, however, that your obligations under this Lease shall continue unabated.

5. End of Lease Options. If you are not in default and if you provide no greater than 150 days and no less than 60 days' prior written notice to XFS, you may, at the end of the Initial Lease Term, either (a) purchase all, but not less than all, of the Equipment "AS IS, WHERE IS" and WITHOUT ANY WARRANTY AS TO CONDITION OR VALUE at the time of purchase by paying its fair market value, as determined by XFS in its sole but reasonable discretion, plus Taxes, (b) enter into a new lease on mutually agreeable terms, or (c) de-install and return the Equipment, at your expense, fully insured, to a continental US location XFS specifies. If you have not elected one of the above options, you shall be deemed to have entered into a new lease with a 3 month term on terms and conditions identical to this Lease, except that either party may terminate the new lease at the end of its 3 month term on 30 days' prior written notice and, when this new lease terminates, shall take one of the actions identified in (a) (b) or (c) in the preceding sentence or be deemed to have entered into another new lease with a 3 month term as provided herein. Any purchase option shall be exercised with respect to each item of Equipment on the day immediately following the date of expiration of the Lease Term of such item, and by the delivery at such time by you to XFS of payment, in cash or by certified check, of the amount of the applicable purchase price for the Equipment. Upon payment of the applicable amount, XFS shall, upon your request, execute and deliver to you a bill of sale for the Equipment on an "AS IS," "WHERE IS," "WITH ALL FAULTS" basis, without representation or warranty of any kind or nature whatsoever. After such payment, you may trade-in the Equipment as part of another transaction with XFS and, if you do, you must pass unencumbered title of the Equipment being traded-in to XFS.

6. Equipment Return. If the Equipment is returned to XFS, it shall be in the same condition as when delivered to you, normal wear and tear excepted and, if not in such condition, you will be liable for all expenses XFS incurs to return the Equipment to such "normal wear and tear" condition. IT IS SOLELY YOUR RESPONSIBILITY TO SECURE ANY SENSITIVE DATA AND PERMANENTLY DELETE SUCH DATA FROM THE INTERNAL MEDIA STORAGE PRIOR TO RETURNING THE EQUIPMENT TO XFS. YOU SHALL HOLD XFS HARMLESS FROM YOUR FAILURE TO SECURE AND PERMANENTLY DELETE ALL SUCH LESSEE DATA AS OUTLINED IN THIS SECTION.

7. Meter Readings and Annual Adjustments. Unless otherwise agreed by you and XFS, you will provide meter readings on all Equipment subject to this Lease at the end of each month during the Initial Lease Term and any additional Term. If you do not provide a timely meter reading, XFS may estimate such reading and invoice you accordingly. If XFS does estimate any meter readings, XFS will make appropriate adjustments on subsequent invoices to you after receiving the actual meter readings from you for the Equipment. At any time after 12 months from the Commencement Date and for each successive 12 month period thereafter during the Initial Lease Term and any 3 month extended Term, XFS may increase your Monthly Lease Payment and the Excess Charges by a maximum of fifteen percent (15%) of the then-current Monthly Lease Payment therefor and you agree to pay such increased amounts.

8. Equipment Delivery and Maintenance. Equipment will be delivered to you by Dealer at the location specified on the first page hereof or in an Equipment schedule, and you agree to execute a Delivery & Acceptance Certificate at XFS's request (and confirm same via telephone and/or electronically) confirming that you have received, inspected and accepted the Equipment, and that XFS is authorized to fund the Dealer for the Equipment. If you reject the Equipment, you assume all responsibility for any purchase order or other contract issued on your behalf directly with Dealer. Equipment may not be moved to another location without first obtaining XFS's written consent, which shall not be unreasonably withheld. You shall permit XFS to inspect Equipment and any maintenance records relating thereto during your normal business hours upon reasonable notice. You represent you have entered into a Maintenance Agreement with Dealer to maintain the Equipment in good working order in accordance with the manufacturer's maintenance guidelines, and to

provide you with supplies for use with the Equipment. You understand and acknowledge that XFS is acting solely as an administrator for Dealer with respect to the billing and collecting of the charges under the Maintenance Agreement and Excess Charges included in the Lease Payments. IN NO EVENT WILL XFS BE LIABLE TO YOU FOR ANY BREACH BY THE DEALER OF ANY OF ITS OBLIGATIONS TO YOU, NOR WILL ANY OF YOUR OBLIGATIONS UNDER THIS LEASE BE AFFECTED, MODIFIED, RELEASED OR EXCUSED BY ANY ALLEGED BREACH BY DEALER.

9. Equipment Ownership, Labeling and UCC Filing. If and to the extent a court deems this Lease to be a security agreement under the UCC, and otherwise for precautionary purposes only, you grant XFS a first priority security interest in your interest in the Equipment and all proceeds thereof in order to secure your performance under this Lease. XFS is and shall remain the sole owner of the Equipment, except the Software. XFS may label the Equipment to identify our ownership interest in it. You authorize XFS to file by any permissible means a UCC financing statement to show, and to do all other acts to protect, our interest in the Equipment. You agree to pay any filing fees and administrative costs for the filing of such financing statements. You agree to keep the Equipment free from any liens or encumbrances and to promptly notify XFS if there is any change in your organization such that a refiling or amendment to XFS's UCC financing statement against you becomes necessary.

10. Assignment. YOU MAY NOT ASSIGN, SELL, PLEDGE, TRANSFER, SUBLEASE OR PART WITH POSSESSION OF THE EQUIPMENT, THIS LEASE OR ANY OF YOUR RIGHTS OR OBLIGATIONS UNDER THIS LEASE (COLLECTIVELY "ASSIGNMENT") WITHOUT XFS'S PRIOR WRITTEN CONSENT, WHICH SHALL NOT BE UNREASONABLY WITHHELD, BUT SUBJECT TO THE SOLE EXERCISE OF XFS'S REASONABLE CREDIT DISCRETION AND EXECUTION OF ANY NECESSARY ASSIGNMENT DOCUMENTATION. If XFS agrees to an Assignment, you agree to pay the applicable assignment fee and reimburse XFS for any costs we incur in connection with that Assignment. XFS may sell, assign or transfer all or any part of the Equipment, this Lease and/or any of our rights (but none of our obligations) under this Lease. XFS's assignee will have the same rights that we have to the extent assigned (but none of our obligations). YOU AGREE NOT TO ASSERT AGAINST SUCH ASSIGNEE ANY CLAIMS, DEFENSES, COUNTERCLAIMS, RECOUPMENTS, OR SET-OFFS THAT YOU MAY HAVE AGAINST XFS, and you agree to remit payments due under this Lease to such Assignee if so designated. XFS agrees and acknowledges that any Assignment by us will not materially change your obligations under this Lease.

11. Taxes. You will be responsible for, indemnify and hold XFS harmless from, all applicable taxes, fees or charges (including sales, use, personal property and transfer taxes, other than net income taxes), plus interest and penalties, assessed by any governmental entity on the Equipment, this Lease or the amounts payable under this Lease (collectively, "Taxes"), which will be included in XFS's invoice to you unless you timely provide continuing proof of your tax exempt status. If Equipment is delivered to a jurisdiction where certain taxes are calculated and paid at the time of lease initiation, you authorize XFS to finance and adjust your Lease Payment to include such Taxes over the Initial Lease Term unless you require otherwise. Unless and until XFS notifies you in writing to the contrary, XFS will file all personal property tax returns covering the Equipment, pay the personal property taxes levied or assessed thereon, and collect from your account all personal property taxes on the Equipment. This is a true lease for all income tax purposes and you will not claim any credit or deduction for depreciation of the Equipment, or take any other action inconsistent with your status as lessee of the Equipment.

12. Equipment Warranty Information and Disclaimers. XFS IS MERELY A FINANCIAL INTERMEDIARY, AND HAS NO INVOLVEMENT IN THE SALE, DESIGN, MANUFACTURE, CONFIGURATION, DELIVERY, INSTALLATION, USE OR MAINTENANCE OF THE EQUIPMENT. THEREFORE, WITH RESPECT TO EQUIPMENT, XFS DISCLAIMS, AND YOU WAIVE SOLELY AGAINST XFS, ALL WARRANTIES, WHETHER EXPRESS OR IMPLIED, INCLUDING, BUT NOT LIMITED TO, THE IMPLIED WARRANTIES OF MERCHANTABILITY, NON-INFRINGEMENT AND FITNESS FOR PARTICULAR PURPOSE, AND XFS MAKES NO REPRESENTATIONS OF ANY KIND OR TYPE, INCLUDING, BUT NOT LIMITED TO, THE EQUIPMENT'S SUITABILITY, FUNCTIONALITY, DURABILITY, OR CONDITION. Since you have selected the Equipment and the Dealer, you acknowledge that you are aware of the name of the manufacturer of each item of Equipment and agree that you will contact each manufacturer and/or Dealer for a description of any warranty rights you may have under the Equipment supply contract, sales order, or otherwise. Provided you are not in default hereunder, XFS hereby assigns to you any warranty rights we may have against Dealer or manufacturer with respect to the Equipment. If the Equipment is returned to XFS, such rights are deemed reassigned by you to XFS. IF THE EQUIPMENT IS NOT PROPERLY INSTALLED, DOES NOT OPERATE AS WARRANTED, BECOMES OBSOLETE, OR IS UNSATISFACTORY FOR ANY REASON WHATSOEVER, YOU SHALL MAKE ALL RELATED CLAIMS SOLELY AGAINST MANUFACTURER OR DEALER AND NOT AGAINST XFS, AND YOU SHALL NEVERTHELESS CONTINUE TO PAY ALL LEASE PAYMENTS AND OTHER SUMS PAYABLE UNDER THIS LEASE.

13. Liability and Indemnification. XFS IS NOT RESPONSIBLE FOR ANY LOSSES, DAMAGES, EXPENSES OR INJURIES OF ANY KIND OR TYPE, INCLUDING, BUT NOT LIMITED TO, ANY SPECIAL, INDIRECT, INCIDENTAL, CONSEQUENTIAL OR PUNITIVE DAMAGES (COLLECTIVELY, "CLAIMS"), TO YOU OR ANY THIRD PARTY CAUSED BY THE EQUIPMENT OR ITS USE, EXCEPT THOSE CLAIMS ARISING DIRECTLY AND PROXIMATELY FROM XFS'S GROSS NEGLIGENCE OR WILLFUL MISCONDUCT. In addition, except for Claims arising directly and proximately from XFS's gross negligence or willful misconduct, you assume the risk of liability for, and hereby agree to indemnify and hold safe and harmless, and covenant to defend, XFS, its employees, officers and agents from and against: (a) any and all Claims (including legal expenses of every kind and nature) arising out of the manufacture, purchase, shipment and delivery of the Equipment to you, acceptance or rejection, ownership, leasing, possession, operation, use, return or other disposition of the Equipment, including, without limitation, any liabilities that may arise from patent or latent defects in the Equipment (whether or not discoverable by you), any claims based on absolute tort liability or warranty and any claims based on patent, trademark or copyright infringement; and (b) any and all loss or damage of or to the Equipment.

14. Default and Remedies. You will be in default under this Lease if (1) XFS does not receive any payment within 10 days after its due date, or (2) you breach any other obligation under this Lease or any other agreement with XFS. If you default, and such default continues for 10 days after XFS provides notice to you, XFS may, in addition to other remedies (including requesting the Dealer to cease performing under the Maintenance Agreement), require you to promptly return the Equipment as provided in Sections 5 and 6 hereof, and require immediate payment, as liquidated damages for loss of bargain and not as a penalty, of the sum of: (a) all amounts then due, plus interest from the due date until paid at the rate of 1.5% per month; (b) the Lease Payments remaining in the Initial Lease Term (including the fixed maintenance component thereof, if permitted under the Maintenance Agreement), discounted at the Discount Rate to the date of default, and (c) Taxes. In addition, if you do not return the Equipment as required above, you agree to pay XFS the fair market value thereof, as reasonably determined by XFS, as of the end of the Initial Lease Term, discounted at the Discount Rate to the date of default. You agree to pay all reasonable costs, including attorneys' fees and disbursements, incurred by XFS to enforce this Lease.

15. Risk of Loss and Insurance. You assume and agree to bear the entire risk of loss, theft, destruction or other impairment of the Equipment upon delivery. You, at your own expense, (i) shall keep Equipment insured against loss or damage at a minimum of full replacement value thereof, and (ii) shall carry public liability insurance against bodily injury, including death, and against property damage in the amount of at least $2 million (collectively, "Required Insurance"). All such Required Insurance shall be with loss payable to "XFS, its successors and/or assigns, as their interests may appear," and shall be with companies reasonably acceptable to XFS. In addition, XFS shall be similarly named as an additional insured on all public liability insurance policies. The Required Insurance shall provide for 30 days' prior notice to XFS of cancellation.

YOU MUST PROVIDE XFS OR OUR DESIGNEES WITH SATISFACTORY WRITTEN EVIDENCE OF REQUIRED INSURANCE WITHIN 30 DAYS OF THE INCEPTION DATE AND ANY SUBSEQUENT WRITTEN REQUEST BY XFS OR OUR DESIGNEES. IF YOU DO NOT DO SO, THEN IN LIEU OF OTHER REMEDIES FOR DEFAULT, XFS IN OUR DISCRETION AND AT OUR SOLE OPTION MAY (BUT IS NOT REQUIRED TO) OBTAIN INSURANCE FROM AN INSURER OF XFS'S CHOOSING, WHICH MAY BE AN XFS AFFILIATE, IN SUCH FORMS AND AMOUNTS AS XFS DEEMS REASONABLE TO PROTECT XFS'S INTERESTS (COLLECTIVELY "EQUIPMENT INSURANCE"). EQUIPMENT INSURANCE WILL COVER THE EQUIPMENT AND XFS; IT WILL NOT NAME YOU AS AN INSURED AND MAY NOT COVER ALL OF YOUR INTEREST IN THE EQUIPMENT AND WILL BE SUBJECT TO CANCELLATION AT ANY TIME. YOU AGREE TO PAY XFS PERIODIC CHARGES FOR EQUIPMENT INSURANCE (COLLECTIVELY "INSURANCE CHARGES") THAT INCLUDE: AN INSURANCE PREMIUM THAT MAY BE HIGHER THAN IF YOU MAINTAINED THE REQUIRED INSURANCE SEPARATELY; A FINANCE CHARGE OF UP TO 1.5% PER MONTH ON ANY ADVANCES MADE BY XFS OR OUR AGENTS; AND COMMISSIONS, BILLING AND PROCESSING FEES; ANY OR ALL OF WHICH MAY GENERATE A PROFIT TO XFS OR OUR AGENTS. XFS MAY ADD INSURANCE CHARGES TO EACH LEASE PAYMENT. XFS shall discontinue billing or debiting Insurance Charges for Equipment Insurance upon receipt and review of satisfactory evidence of Required Insurance.

You must promptly notify XFS of any loss or damage to Equipment which makes any item of Equipment unfit for continued or repairable use. You hereby irrevocably appoint XFS as your attorney-in-fact to execute and endorse all checks or drafts in your name to collect under any such Required Insurance. Insurance proceeds from Required Insurance or Equipment Insurance received shall be applied, at XFS's option, to (x) restore the Equipment so that it is in the same condition as when delivered to you (normal wear and tear excepted), or (y) if the Equipment is not restorable, to replace it with like-kind condition Equipment from the same manufacturer, or (z) pay to XFS the greater of (i) the total unpaid Lease Payments for the entire term hereof (discounted to present value at the Discount Rate) plus XFS's residual interest in such Equipment (herein agreed to be 20% of the Equipment's original cost to XFS, discounted to present value at the Discount Rate) plus any other amounts due to us under this Lease, or (ii) the fair market value of the Equipment immediately prior to the loss or damage, as determined by XFS. NO LOSS OR DAMAGE TO EQUIPMENT, OR XFS'S RECEIPT OF INSURANCE PROCEEDS, SHALL RELIEVE YOU OF ANY OF YOUR REMAINING OBLIGATIONS UNDER THIS LEASE. Notwithstanding procurement of Equipment Insurance or Required Insurance, you remain primarily liable for performance under subclauses (x), (y) or (z) in the third sentence of this paragraph in the event the applicable insurance carrier fails or refuses to pay any claim. YOU AGREE (I) AT XFS'S SOLE ELECTION, TO ARBITRATE ANY DISPUTE WITH XFS, OUR AGENTS OR ASSIGNS REGARDING THE EQUIPMENT INSURANCE AND/OR INSURANCE CHARGES UNDER THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION IN FAIRFIELD COUNTY, CT, (II) THAT IF XFS MAKES THE FOREGOING ELECTION, ARBITRATION (NOT A COURT) SHALL BE THE EXCLUSIVE REMEDY FOR SUCH DISPUTES; AND (III) THAT CLASS ARBITRATION IS NOT PERMITTED. This arbitration option does not apply to any other provision of this Lease.

16. Finance Lease and Lessee Waivers. The parties agree this Lease is a "finance lease" under UCC Article 2A. You waive, solely against XFS and its successors and assigns, (a) all rights and remedies conferred on a lessee under Article 2A (Sections 508-522) of the UCC (C.G.S.A. §§42a-2A-724–737), and (b) any rights you now or later may have which require XFS to sell, lease or otherwise use any Equipment to reduce our damages including our realization of the remaining value of the Equipment, or which may otherwise limit or modify any of our rights or remedies.

17. Authorization of Signer and Credit Review. You represent that you may lawfully enter into, and perform, this Lease, that the individual signing this Lease on your behalf has all necessary authority to do so, and that all financial information you provide completely and accurately represents your financial condition. You agree to furnish financial information that XFS may request now, including your tax identification number, and you authorize XFS to obtain credit reports on you in the future should you default or fail to make prompt payments under this Lease.

18. Original and Sole Controlling Document; No Modifications Unless in Writing. This Lease constitutes the entire agreement between the Parties as to the subjects addressed herein, and representations or statements not included herein are not part of this Lease and are not binding on the Parties. You agree that an executed copy of this Lease that is signed by your authorized representative and by XFS's authorized representative (an original manual signature or such signature reproduced by means of a reliable electronic form, such as electronic transmission of a facsimile or electronic signature) shall be marked "original" by XFS and shall constitute the only original document for all purposes. All other copies shall be duplicates. To the extent this Lease constitutes chattel paper (as defined in the UCC), no security interest in this Lease may be created except by the possession or transfer of the copy marked "original" by XFS. IF A PURCHASE ORDER OR OTHER DOCUMENT IS ISSUED BY YOU, NONE OF ITS TERMS AND CONDITIONS SHALL HAVE ANY FORCE OR EFFECT, AS THE TERMS AND CONDITIONS OF THIS LEASE EXCLUSIVELY GOVERN THE TRANSACTION DOCUMENTED HEREIN. THE DEALER AND ITS REPRESENTATIVES ARE NOT OUR AGENTS AND ARE NOT AUTHORIZED TO MODIFY OR NEGOTIATE THE TERMS OF THIS LEASE. THIS LEASE MAY NOT BE AMENDED OR SUPPLEMENTED EXCEPT IN A WRITTEN AGREEMENT SIGNED BY AUTHORIZED REPRESENTATIVES OF THE PARTIES AND NO PROVISIONS CAN BE WAIVED EXCEPT IN A WRITING SIGNED BY XFS. XFS's failure to object to terms contained in any communication from you will not be a waiver or modification of the terms of this Lease. You authorize XFS to insert or correct missing information on this Lease, including but not limited to your proper legal name, lease numbers, serial numbers and other information describing the Equipment, so long as there is no material impact to your financial obligations.

19. Governing Law, Jurisdiction, Venue and JURY TRIAL WAIVER. THIS LEASE IS GOVERNED BY, AND SHALL BE CONSTRUED IN ACCORDANCE WITH, THE LAWS OF THE STATE OF CONNECTICUT (WITHOUT REGARD TO CONFLICT OF LAW PRINCIPLES THAT WOULD OTHERWISE REQUIRE APPLICATION OF LAWS OF ANOTHER JURISDICTION). THE JURISDICTION AND VENUE OF ANY ACTION TO ENFORCE THIS LEASE, OR OTHERWISE RELATING TO THIS LEASE, SHALL BE IN A FEDERAL OR STATE COURT IN FAIRFIELD COUNTY, CONNECTICUT OR, EXCLUSIVELY AT XFS'S OPTION, IN ANY OTHER FEDERAL OR STATE COURT WHERE THE EQUIPMENT IS LOCATED OR WHERE XFS'S OR YOUR PRINCIPAL PLACES OF BUSINESS ARE LOCATED, AND YOU HEREBY WAIVE ANY RIGHT TO TRANSFER VENUE. THE PARTIES HEREBY WAIVE ANY RIGHT TO TRIAL BY JURY IN ANY ACTION RELATED TO OR ARISING OUT OF THIS LEASE.

20. Miscellaneous. Your obligations under the "Taxes" and "Liability" Sections commence upon execution, and survive the expiration or earlier termination, of this Lease. Notices under this Lease must be in writing. Notices to you will be sent to the "Billing Address" provided on the first page hereof, and notices to XFS shall be sent to our address provided on the first page hereof. Notices will be deemed given 5 days after mailing by first class mail or 2 days after sending by nationally recognized overnight courier. Invoices are not considered notices and are not governed by the notice terms hereof. You authorize XFS to communicate with you by any electronic means (including cellular phone, email, automatic dialing and recorded messages) using any phone number (including cellular) or electronic address you provide to us. If a court finds any term of this Lease unenforceable, the remaining terms will remain in effect. The failure by either Party to exercise any right or remedy will not constitute a waiver of such right or remedy. If more than one party has signed this Lease as lessee, each such party agrees that its liability is joint and several. The following four sentences control over every other part of this Lease. Both Parties will comply with applicable laws. XFS will not charge or collect any amounts in excess of those allowed by applicable law. Any part of this Lease that would, but for the last four sentences of this Section, be read under any circumstances to allow for a charge higher than that allowed under any applicable legal limit, is modified by this Section to limit the amounts chargeable under this Lease to the maximum amount allowed under the legal limit. If, in any circumstances, any amount in excess of that allowed by law is charged or received, any such charge will be deemed limited by the amount legally allowed and any amount received by XFS in excess of that legally allowed will be applied by us to the payment of amounts legally owed under this Lease or refunded to you.

Xerox Financial Services LLC
45 Glover Avenue
Norwalk, CT 06856

xerox

Equipment Schedule A

Lease Agreement Number 87393

EQUIPMENT

Quantity	Model and Description
1	Xerox C8070 ✓
1	Xerox B8075 ✓
1	Xerox B8045 ✓
1	Xerox B7030 ✓
1	Xerox C8035 ✓
10	Xerox B605 ✓

Authorized Signer	Date 12/28/17
X [signature]	Title
Print Name Malcolm E. Mason	Director of IT Business Intelligence

PITNEY BOWES LEASE AGREEMENT

Agreement Number: | | | | | | | | | | |

Your Business Information

MONTOWESE HEALTH CARE CENTER		061060258
Full Legal Name of Lessee	DBA Name of Lessee	Tax ID # (FEIN/TIN)
163 QUINNIPIAC AVE	NORTH HAVEN	CT 06473-3687
Billing Address: Street	City	State Zip+4
	( ) ext	15118970886
Billing Contact Name	Billing Contact Phone #	Billing CAN #
163 QUINNIPIAC AVE	NORTH HAVEN	CT 06473-3687
Installation Address *(If different from billing address)* : Street	City	State Zip+4
Helen Raucci	(203) 624 3303 ext 310_	15118970886
Installation Contact Name	Installation Contact Phone #	Installation CAN #
Invoice Attention To	Lessee PO #	

Your Business Needs

Qty	Business Solution Description
	Mail Creation - 1
1	DM225 Digital Mailing System
1	IntelliLink Interface / PSD for DM125 / DM225
1	Basic Accounting (25 Dept) Software
1	10 lb Integrated Weighing
1	Professional Installation
1	Integrated Weighing Platform
1	pbSmartPostage Free
1	IntelliLink Subscription
1	Digital Access Connection Accepted

Check additional items to be included in client's payment

- [X] **Service Level Agreement**
  Standard - Provides maintenance and support for equipment
- [ ] **Software Maintenance (additional terms apply)** - *Provides revision updates & technical assistance*
- [X] **Meter Rental**
  ( ) Value Based Services (not including USPS fees which will be charged separately)
- [X] **Purchase Power®** - *A line of credit providing a convenient way to mail now and pay later. Consolidate meter postage, permit postage and supplies under one account — see terms & conditions*
- [ ] **Equipment Replacement Program** – *Protection in case of loss or damage to leased equipment*
  ( )Yes I want to enroll in the ValueMAX® equipment replacement program
  (x) No Enrollment (I will provide proof of insurance within the next 30 days as noted in Section L9)

If green products are identified on your Order, the equipment covered by this Agreement includes remanufactured products that have gone through our factory certification testing process.

Your Payment Plan

Initial Term : 63 months

Number Of Months		Monthly Amount	Billed Quarterly At*
First	63	$167	$501

( ) Required advance check of $( ) received
( ) Tax Exempt Certificate Attached
( ) Tax Exempt Certificate Not Required

**Does not include any applicable sales, use, or property taxes which will be billed separately; payment plans begin after any applicable Interim Usage Period.*

Your Signature Below

By signing below, you agree to be bound by all the terms of this Agreement, including those located in the Pitney Bowes Terms (Version 5/15), which are available at www.pb.com/termsconditions and are incorporated by reference. **You acknowledge that you may not cancel the Lease (as defined in Section G1 of the Pitney Bowes Terms) for any reason and that all payment obligations are unconditional.** The Lease will be binding on us after we have completed our credit and documentation approval process and have signed below. The Lease requires you either to provide proof of insurance or participate in the ValueMAX equipment replacement program (see Section L9 of the Pitney Bowes Terms) for an additional fee.

[signature]	
Lessee Signature	Pitney Bowes Signature
Mark Panico	
Print Name	Print Name
Purchasing	
Title	Title
ASST ADMN / CFO	
Date	Date
helen@montowesehealth.com	
Email Address	

Sales Information

Jacqueline Ahern	007
Account Rep Name	District Office

See Pitney Bowes Terms for additional terms and conditions

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State of Connecticut
Annual Report of Long-Term Care Facility
CSP-7 Rev. 6/95

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitatio	2442	9/30/2018	7	37

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

⊙ Accrual O Cash O Modified Cash

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

Facility changed ownership 1/25/18

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1	
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	$
2	$
3	$
4	$
	Charge for Services Provided $

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

⊙ Yes O No Pg 15, Line1d

Legal Services Information

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

Address (*No. & Street, City, State, Zip Code*)
1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	$
2	$
3	$
4	$
5	$
	Charge for Services Provided $

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

⊙ Yes O No Pg 15, Line1e

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page 8 of 37
Montowese Health & Rehabilitation Center	2442	9/30/2018	

	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30 Total	Period 10/1 Thru 6/30 CCNH	Period 10/1 Thru 6/30 RHNS	Period 10/1 Thru 6/30 (Specify)	Period 7/1 Thru 9/30 Total	Period 7/1 Thru 9/30 CCNH	Period 7/1 Thru 9/30 RHNS	Period 7/1 Thru 9/30 (Specify)
1. Certified Bed Capacity A. On last day of PREVIOUS report period	120	120			120	120			120	120		
B. On last day of THIS report period	120	120			120	120			120	120		
2. Number of Residents A. As of midnight of PREVIOUS report period												
B. As of midnight of THIS report period	116	116			103	103			116	116		
3. Total Number of Days Care Provided During Period A. Medicare	13,558	13,558			8,587	8,587			4,971	4,971		
B. Medicaid (Conn.)	9,582	9,582			5,407	5,407			4,175	4,175		
C. Medicaid (other states)												
D. Private Pay	1,342	1,342			772	772			570	570		
E. State SSI for RCH												
F. Other (Specify) Managed Care	1,995	1,995			1,513	1,513			482	482		
G. Total Care Days During Period (3A thru F)	26,477	26,477			16,279	16,279			10,198	10,198		
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	2	2							2	2		
5. *Total Resident Days* **(3G + 4A + 4B)**	26,479	26,479			16,279	16,279			10,200	10,200		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2018	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
				Lost			Gained						
	CCNH (1)	RHNS (2)	(Specify) (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 CCNH	Medicaid CCNH	Medicaid RHNS	Self-Pay CCNH	Self-Pay RHNS	Self-Pay (Specify)	Other State Assisted R.C.H.	Other State Assisted ICF-MR
No. of Residents	40	49		5		22		
Per Diem Rate								
a. One bed rm.	567.24	241.40		540.00		438.09		
b. Two bed rms.	567.24	241.40		490.00		438.09		
c. Three or more bed rms.	567.24	241.40		440.00		438.09		

Item	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	400	400		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	910	910		
2. Restorative Treatments				
C. Other	10,356	10,356		
D. ***Total Physical Therapy Treatments***	11,666	11,666		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	44	44		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	16	16		
2. Restorative Treatments				
C. Other	632	632		
D. ***Total Speech Therapy Treatments***	692	692		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	501	501		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	889	889		
2. Restorative Treatments				
C. Other	10,881	10,881		
D. ***Total Occupational Therapy Treatments***	12,271	12,271		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2018	10	37

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

Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
	Total Cost and 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)	136,914	1,613				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	220,675	11,788				
5. Dietary Service						
a. Head Dietitian	22,511	634				
b. Food Service Supervisor	42,472	1,489				
c. Dietary Workers	237,966	18,587				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	33,578	1,278				
b. Other Maintenance Workers	52,090	3,041				
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	179,068	3,038				
b. RN						
1. Direct Care	944,287	27,785				
2. Administrative**	647,442	28,038				
c. LPN						
1. Direct Care	588,337	22,325				
2. Administrative**						
d. Aides and Attendants	1,035,222	76,109				
e. Physical Therapists	762,018	25,640				
f. Speech Therapists	89,496	2,221				
g. Occupational Therapists	578,776	19,277				
h. Recreation Workers	64,022	4,227				
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	135,106	5,168				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	5,769,980	252,258				

* 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
	$ -	-	$ -	-	$ -	-
Medical Staff Meetings	$ 2,950	19	$ -	-	$ -	-
	$ -	-	$ -	-	$ -	-
	$ -	-	$ -	-	$ -	-
	$ -	-	$ -	-	$ -	-
	$ -	-	$ -	-	$ -	-
	$ -	-	$ -	-	$ -	-
	$ -	-	$ -	-	$ -	-
	$ -	-	$ -	-	$ -	-
	$ -	-	$ -	-	$ -	-
	$ -	-	$ -	-	$ -	-
	$ -	-	$ -	-	$ -	-
	$ -	-	$ -	-	$ -	-
	$ -	-	$ -	-	$ -	-
Total	$ 2,950	19	$ -	-	$ -	-

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

Name of Facility				License No.		Report for Year Ended			Page	of
Montowese Health & Rehabilitation Center				2442		9/30/2018			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										
Not Applicable										
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).										
Not Applicable										

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
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
Montowese Health & Rehabilitation Center	2442	9/30/2018	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* **										
Mark Panico (10/1/17 - 8/21/18)	109,531			Health & Life Insuracne, Payroll Taxes	Day to day operations if the nursing home facility	1,296	A2			
John Sweeney (8/21/18 - 9/30/18)	27,383			Health & Life Insuracne, Payroll Taxes	Day to day operations if the nursing home facility	317	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility Montowese Health & Rehabilitation Center	License No. 2442		Report for Year Ended 9/30/2018		Page 13	of 37
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist	9,790	96				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	5,816	92				
b. Other	23,352	423				
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	24,000	210				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting						
c. Resident Care**	4,383	38				
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
	2,950	19				
9. Speech Therapist						
a. Resident Care	4,403	13				
b. Other						
10. Occupational Therapist						
a. Resident Care	2,080	54				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	76,774	945				

* 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.

Montowese
Medical Director Schedule
9/30/2018

Name	Expense	Hours	Title
Bjorn Ringstad, MD	24,000	210	Medical Director

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-14 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2018	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers: Yes	Related** to Owners, Operators, Officers: No	Explanation of Relationship
Dr. Xioming Hong, 12 Village Street, North Haven, CT 06473	Physician-Medical Director	○	⦿	
Dr. Bjorn Ringstad, 12 Village Street, North Haven, CT 06473	Physician-Medical Director	○	⦿	
Dr. Dharini Sun, 2690 Whitey Avenue, Hamden, CT 06518	Physician-Medical Director	○	⦿	
Village Medical Associates, 12 Village Street, North Haven, CT 06473	Physician-Medical Director	○	⦿	
Dr. Aline Alfirii, 31 Laurel Street, West Haven, CT 06516	Medical Staff	○	⦿	
Dr. Quiyam Mujtaba, 750 Savin Avenue, West Haven, CT 06516	Medical Staff	○	⦿	
West Haven Medical Group, 322 East Main Street, Ste 1B, Brandford, CT 06405	Physician	○	⦿	
Pact, LLC, 322 East Main Street, Ste 1B, Brandford, CT 06405	Physician	○	⦿	
Foremost Rehab of CT, LLC, 1157 Highland Ave, Ste 101, Cheshire, CT 06410	Physical Therapy	○	⦿	
Masstex Imaging, LLC, 3 Electronics Ave, Ste 201, Danvers, MA 01923	Speech Therapy	○	⦿	
SDX Dysphagia Experts, 21 Waterville Rd, Avon, CT 06001	Speech Therapy	○	⦿	
Omnicare, Inc., Dept. 781668, PO Box 78000, Detroit, MI 48278	Pharmacist	○	⦿	
Procare LTC Pharmacy, 110 Bi-County Blvd, Ste 121, Farmingdale, NY 11735	Pharmacist	⦿	○	Common Owners: Minority Interest
		○	○	
		○	○	
Integrative Healthcare Solutions, LLC, 48 Skyview Drive, Trumbull, CT 06611	RN Administrative	○	⦿	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2018	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	178,455	178,455		
2. Disability Insurance	$				
3. Unemployment Insurance	$	90,875	90,875		
4. Social Security (F.I.C.A.)	$	430,200	430,200		
5. Health Insurance	$	430,443	430,443		
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	33,890	33,890		
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*	$	12,695	12,695		
d. Accounting and Auditing	$				
e. Legal (*Services should be fully described on Page 7)*	$				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	50,072	50,072		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	7,523	7,523		
2. Cellular Phones	$				
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*) See Attached Schedule	$				
3. Resident Day User Fee	$	271,599	271,599		
Subtotal	$	1,505,752	1,505,752		

* 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**

Montowese Health & Rehabilitation Center
9/30/2018

Attachment Page 15

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

State of Connecticut
Annual Report of Long-Term Care Facility
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	9/30/2018	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,505,752	1,505,752		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$	2,840	2,840		
4. Employee Travel	$	3,120	3,120		
5. Education Expenses Related to Seminars and Conventions	$	18,042	18,042		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*) See Attached Schedule	$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$				
2. Advertising Telephone Directory (*all such expenses*)***	$	8,931	8,931		
3. Advertising Other (*Specify*)*** See Attached Schedule	$	2,387	2,387		
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)***	$	3,716	3,716		
7. Postage	$	779	779		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	5,613	5,613		
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**	$	235,386	235,386		
13. Other (*Specify*) See Attached Schedule	$	157,123	157,123		
C-14 Total Administrative & General Expenditures	$	1,943,689	1,943,689		

* 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	$ 2,387	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
Total Other Advertising	$ 2,387	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
	$ -	$ -	$ -
	$ -	$ -	$ -
CAHCF Dues	$ 5,613	$ -	$ -
		$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
Total Dues	$ 5,613	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
	$ -	$ -	$ -
	$ -	$ -	$ -
Bank Charges	$ 9,910	$ -	$ -
Payroll Processing Fees	$ 20,999	$ -	$ -
Employee Physicals/Background Checks	$ 3,323	$ -	$ -
Data Processing/ Software Maint. Fees	$ 43,221	$ -	$ -
Compliance Consulting	$ 79,670	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
Total Other Administrative and General	$ 157,123	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health & Rehabilitation Cent	2442	9/30/2018	17 | 37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	356,646	Contract Attached to a Prior Year	See Below
Allocation of the Above	$235386.36 $57063.36 $64196.28	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12 Pg 18, Line 2C Pg 20, Line 5J

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health & Rehabilitation Center	2442	9/30/2018	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	288,381	288,381		
2. Non-Food Supplies	$	19,446	19,446		
3. Other (*Specify*)____ Dishes = $896	$	896	896		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	48,722	48,722		
c. Management Services**	$	57,063	57,063		
d. Other (*Specify*)____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	414,508	414,508		

2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*	319	319		

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

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

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	9/30/2018	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $	95,896	95,896		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*) Supplies = $9,169	$	9,169	9,169		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	105,065	105,065		

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

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

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

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

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	9/30/2018	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping a. In-House Care	Sq. Ft. Serviced by Personnel					
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	311,504	311,504		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	311,504	311,504		
5. Resident Care (Supplies)** a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from OmniCare Pharmacy and Procare Pharmacy		$	618,530	618,530		
b. Medicine Cabinet Drugs		$	30,871	30,871		
c. Medical and Therapeutic Supplies		$	229,494	229,494		
d. Ambulance/Limousine***		$	221	221		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	39,727	39,727		
f. X-rays and Related Radiological Procedures***		$	40,437	40,437		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	111,674	111,674		
i. Recreation		$	4,122	4,122		
j. Other (Specify)**** See Attached Schedule		$	133,180	133,180		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	1,208,256	1,208,256		

* 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.

Montowese Health & Rehabilitation Center
9/30/2018

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
0	$ -	$ -	$ -
Management Fee Direct	$ 64,196	$ -	$ -
	$ -	$ -	$ -
Cable TV	$ 15,119	$ -	$ -
Medical Equip Rentals-Medicaid	$ 6,124	$ -	$ -
Physical Therapy Supplies	$ 21,962	$ -	$ -
Occupational Therapy Supplies	$ 1,495	$ -	$ -
Oxygen Equipment Rentals	$ 16,312	$ -	$ -
Medical Equip Rentals-Other	$ 7,972	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
Total Other Resident Care	$ 133,180	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 10/2001

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

Name of Facility: Montowese Health & Rehabilitation Center	License No.: 2442	Report for Year Ended: 9/30/2018	Page 21 of 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
Omnicare, Inc (Pharmacy)	78000, Detroit, MI 48278-1668	○	⊙		Pharmacy Services	183,766			20 & 1	5A2 &
Procare LTC Pharmacy	111 Excutive Blvd Farmingdale NY 11735	⊙	○	Common Owners:Minority Interest	Pharmacy Services	668,652			20	5A2 &
ADP	PO Box 842875, Boston, MA 02284-2875	○	⊙		Payroll Processing	12,303			16	m13
Executive Landscaping	PO Box 185790, Hamden, CT 06518	○	⊙		Landscaping and Snow Removal Services	19,258			22	6f
CWPM, LLC	25 Norton Place, Plainville, CT 06062	○	⊙		Rubbish Removal	11,783			22	6f
		○	○						19	3A4
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health & Rehabilitation Center	2442	9/30/2018	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	81,108	81,108		
b. Heat	$	34,694	34,694		
c. Light & Power	$	105,323	105,323		
d. Water	$	27,451	27,451		
e. Equipment Lease (*Provide detail on page 6*)	$	14,253	14,253		
f. Other (*itemize*)	$	65,760	65,760		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	328,589	328,589		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$				
d. Movable Equipment	$	73,784	73,784		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	73,784	73,784		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	3,236	3,236		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	3,236	3,236		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	408,217	408,217		
10. Property Taxes					
a. Real estate taxes paid by owner	$	92,051	92,051		
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	8,733	8,733		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	586,021	586,021		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
	$ -	$ -	$ -
Groundskeeping	$ 19,630	$ -	$ -
Rubbish Removal	$ 20,534	$ -	$ -
Snow Removal	$ 7,535	$ -	$ -
Supplies	$ 18,061	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
Total Other Repairs and Maintenance	$ 65,760	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-23 Rev. 10/2006

Depreciation Schedule

Name of Facility Montowese Health & Rehabilitation Center	License No. 2442	Report for Year Ended 9/30/2018	Page 23	of 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												
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2018	712,486		712,486		S/L	Various	73,784	
D-3. Subtotal												73,784
E. ***Total Depreciation***												73,784

Montowese Health & Rehabilitation Center
9/30/2018

Schedule of Land Improvements Acquired during this report period

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

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

Schedule of Building Improvements Acquired during this report period

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

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

Schedule of Non-Movable Equipment Acquired during this report period

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Various	See Attached	$ 712,486	Various	$ 73,784	
Total additions for Movable Equipment		$ 712,486		$ 73,784	*
Deletions:					
Various				$ -	
		$ -	-	$ -	
		$ -	-	$ -	
		$ -	-	$ -	
		$ -	-	$ -	
		$ -	-	$ -	
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:					
Various	See attached	$ 46,637	Various	$ 3,236	
Total additions for Leasehold Improvement		$ 46,637		$ 3,236	*
Deletions:					
		$ -	-	$ -	
		$ -	-	$ -	
		$ -	-	$ -	
Total deletions for L		$ -	-	$ -	
*Ties to Page 24, I		$ -	-	$ -	
**Ties to Page 24, I		$ -	-	$ -	
Total deletions for Leasehold Improvement		$ -		$ -	**

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

Montowese Health &
Rehabilitation Center
9/30/2018

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Feb-18	Set Up	$ 5,050	3	$ 842
Mar-18	Computer Equipment	$ 7,779	3	$ 1,296
Apr-18	Microsoft Business & Hard Drives	$ 852	3	$ 142
May-18	Rehab Equipment	$ 7,651	5	$ 765
May-18	Laptop/Desktop	$ 6,795	3	$ 1,133
May-18	Device Measurement Bed System	$ 1,224	5	$ 122
Jul-18	MS Windows Pro	$ 2,003	3	$ 334
Jul-18	Ice Machine Controller	$ 1,011	5	$ 101
Jul-18	Bladder Scanner	$ 8,979	7	$ 641
Aug-18	Acer Computers Kiosks for PCC	$ 9,505	3	$ 1,584
Aug-18	Fortinet Hardware	$ 1,076	3	$ 179
Sep-18	State Machines	$ 2,575	3	$ 429
Sep-18	Clinical Module	$ 5,075	3	$ 846
Sep-18	Pharmacy Configuration	$ 1,162	3	$ 194
Sep-18	Dryer Motor	$ 1,749	5	$ 175
Jan-18	Closing Entry Net Movable Equipment	$ 650,000	5	$ 65,000
Total additions for Movable Equipment		$ 712,486		$ 73,784 *
Deletions:				
Various				
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:				
Jan-18	Fire Caulking	$ 14,640	5	$ 1,464
Feb-18	Telescopic Sliding Door Control	$ 1,878	5	$ 188
Mar-18	Emergency Stop Button and Conduit Wiring	$ 1,740	20	$ 44
Apr-18	Signs and Installation	$ 12,421	10	$ 621
May-18	Roof Exhaust Fan Unit	$ 2,255	10	$ 113
Jul-18	Ran Wire for New Outlets	$ 950	20	$ 24
Jul-18	Junipers	$ 596	10	$ 30
Aug-18	Sprinkler Heads	$ 6,977	10	$ 349
Aug-18	Sprinkler Heads	$ 666	10	$ 33
Aug-18	PVC Hanging Sin	$ 510	10	$ 26
Sep-18	Key Pad	$ 1,104	10	$ 55
Sep-18	Door rail, guides, and rollers	$ 2,901	5	$ 290
Total additions for Leasehold Improvements		$ 46,637		$ 3,236 *
Deletions:				
Total deletions for Leasehold Improvements		$ -		$ - **

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

Amortization Schedule*

Name of Facility Montowese Health & Rehabilitation Center	License No. 2442	Report for Year Ended 9/30/2018	Page 24 of 37

Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. **Organization Expense** 1.									
2.							:		
3.									
A-4. Subtotal									
B. **Mortgage Expense** 1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other** 1. Acquired prior to this report period		2018							
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2018		46,637		S/L		3,236	
C-4. Subtotal									3,236
D. ***Total Amortization***									3,236

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-25 Rev. 9/2002

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	9/30/2018	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 9/30/18	12,800,000			
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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-26 Rev. 6/95

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

Name of Facility Montowese Health & Rehabilitation	License No. 2442	Report for Year Ended 9/30/2018	Page 26 of 37

Item		Total	CCNH	RHNS	(Specify)
12. Interest A. Building, Land Improvement & Non-Movable Equipment 1. First Mortgage	$				
Name of Lender	Rate				
Address of Lender 0					
2. Second Mortgage	$				
Name of Lender	Rate				
Address of Lender 0					
3. Third Mortgage	$				
Name of Lender	Rate				
Address of Lender 0					
4. Fourth Mortgage	$				
Name of Lender	Rate				
Address of Lender 0					
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*)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-27 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health & Rehabilitatic	2442	9/30/2018	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 0							
2. Other (*Specify*)			$				
A. Item	Rate	Amount					
Lender							
Address of Lender 0							
B. Item	Rate	Amount					
Lender							
Address of Lender 0							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)			$				
12. D. Other Interest Expense (*Specify*) Vender Interest = $5,555			$	5,555	5,555		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)			$	5,555	5,555		
14. Insurance a. Insurance on Property (buildings only)			$	44,260	44,260		
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)***			$	44,260	44,260		
15. ***Total All Expenditures (A-13 thru C-14)***			$	10,794,201	10,794,201		

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health & Rehabilitation Center	2442	9/30/2018	28 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages								
1.			Outpatient Service Costs	$				
2.			Salaries not related to Resident Care	$				
3.	10	A12g	Occupational Therapy	$	578,776	578,776		
4.			Other - See attached Schedule	$				
Page 13 - Professional Fees								
5.	13	B8c	Resident Care Physicians **	$	4,383	4,383		
6.	13	B10a	Occupational Therapy	$	2,080	2,080		
7.			Other - See attached Schedule	$				
Pages 15 & 16 - Administrative and General								
8.	15	1a9	Discriminatory Benefits	$				
9.	15	1c	Bad Debts	$	12,695	12,695		
10.			Accounting & Legal	$				
11.	30	IV3	Telephone	$				
12.			Cellular Telephone	$				
13.			Life insurance premiums on the life of Owners, Partners, Operators	$				
14.	16	1 3	Gifts, flowers and coffee shops	$	2,840	2,840		
15.	16	1 5	Education expenditures to colleges or universities for tuition and related costs for owners and employees	$	10,951	10,951		
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	$	10,951	10,951		
17.			Automobile Expense (e.g. personal use)	$				
18.	16	m2&3	Unallowable Advertising *	$	11,318	11,318		
19.			Income Tax / Corporate Business Tax	$				
20.			Fund Raising / Contributions	$				
21.	16	m12	Unallowable Management Fees	$	159,125	159,125		
22.	16	m6	Barber and Beauty	$	3,884	3,884		
23.			Other - See attached Schedule	$	89,580	89,580		
Page 18 - Dietary Expenditures								
24.	18	2a1	Meals to employees, guests and others who are not residents	$				
Page 19 - Laundry Expenditures								
25.	19	3d	Laundry services to employees, guests and others who are not residents	$				
Page 20 - Housekeeping Expenditures								
26.	20	4d	Housekeeping services to employees, guests and others who are not residents	$				
			Subtotal (Items 1 - 26)	$	886,583	886,583		

* 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.

Montowese Health & Rehabilitation Center
9/30/2018

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M13	Bank Charges	$ 9,910	$ -	$ -
16	M13	Compliance Consulting	$ 79,670	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
Total Other A&G Adjustments			$ 89,580	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-29 Rev. 10/2006

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

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health & Rehabilitation Center	2442	9/30/2018	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	886,583	886,583		
Page 20 - Resident Care Supplies*								
27.	20	5a1&	Prescription Drugs	$	618,530	618,530		
28.	20	5d	Ambulance/Limousine	$	221	221		
29.	20	5f	X-rays, etc	$	40,437	40,437		
30.	20	5h	Laboratory	$	111,674	111,674		
31.	20	5c	Medical Supplies	$	20,886	20,886		
32.	20	5e2	Oxygen (non emergency)	$	39,727	39,727		
33.	20	5j	Occupational Therapy	$	1,495	1,495		
34.			Other - See Attached Schedule	$	98,832	98,832		
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$	32,500	32,500		
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.			Research or Experimental Activities	$				
43.	20	5j	Radio and Television Revenue	$	12,663	12,663		
44.			Vending Machine Revenue	$				
45.			Purchase Discounts and Allowances	$				
46.			Duplications of functions or services	$				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	$				
48.	30	IV5	Interest Income on Accounts Rec	$	240	240		
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	$				
Not For Profit Providers Only								
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	$				
51.			***Total Amount of Decrease (Items 1 - 50)***	$	1,863,788	1,863,788		

*** 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

Montowese Health & Rehabilitation Center
9/30/2018

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
			$ -	$ -	$ -
20	5j	Medical Equipment Rental - Other	$ 7,972	$ -	$ -
20	5b	Ebox	$ 8,886	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
18	2c	Unallowable Management Fees............-Indirect Care	$ 38,576	$ -	$ -
20	5j	Unallowable Management Fees............-Direct Care	$ 43,398	$ -	$ -
Total Other Ancillary Costs			$ 98,832	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Equipment Depreciation Carry Forward Adjustment	$ 32,500	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
Total Excess Movable Equipment Depreciation			$ 32,500	$ -	$ -

Schedule of Other Property Adjustments

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

Cost Year		Montowese Amount	Totals	
		2018 Purchased Moveable equipment		
	Cost	$ 650,000	$ 650,000	
	Term	10.00		
2018	Deprec	$ 32,500	$ 32,500	pg 29a Line 26
2018	Book Value	$ 617,500	$ 617,500	BS Line 242
2019	Deprec	$ 65,000	$ 65,000	
2019	Book Value	$ 552,500	$ 552,500	
2020	Deprec	$ 65,000	$ 65,000	
2020	Book Value	$ 487,500	$ 487,500	
2021	Deprec	$ 65,000	$ 65,000	
2021	Book Value	$ 422,500	$ 422,500	
2022	Deprec	$ 65,000	$ 65,000	
2022	Book Value	$ 357,500	$ 357,500	
2023	Deprec	$ 65,000	$ 65,000	
2023	Book Value	$ 292,500	$ 292,500	
2024	Deprec	$ 65,000	$ 65,000	
2024	Book Value	$ 227,500	$ 227,500	
2025	Deprec	$ 65,000	$ 65,000	
2025	Book Value	$ 162,500	$ 162,500	
2026	Deprec	$ 65,000	$ 65,000	
2026	Book Value	$ 97,500	$ 97,500	
2027	Deprec	$ 65,000	$ 65,000	
2027	Book Value	$ 32,500	$ 32,500	
2028	Deprec	$ 32,500	$ 32,500	
2028	Book Value	$ -	$ -	
2029	Deprec		$ -	
2029	Book Value		$ -	
2030	Deprec		$ -	
2030	Book Value		$ -	
2031	Deprec		$ -	
2031	Book Value		$ -	
2032	Deprec		$ -	
2032	Book Value		$ -	
2033	Deprec		$ -	
2033	Book Value		$ -	
2034	Deprec		$ -	
2034	Book Value		$ -	
2035	Deprec		$ -	
2035	Book Value		$ -	
2036	Deprec		$ -	
2036	Book Value		$ -	
2037	Deprec		$ -	
2037	Book Value		$ -	
2038	Deprec		$ -	
2038	Book Value		$ -	
2039	Deprec		$ -	
2039	Book Value		$ -	

Schedule of Other Adjustments

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

Schedule of Unallowable Building Interest

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-30 Rev.10/2005

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health & Rehabilitation Cent	2442	9/30/2018	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	4,242,100	4,242,100		
b. Medicaid Room and Board Contractual Allowance **	$	(1,934,775)	(1,934,775)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	4,550,632	4,550,632		
b. Medicare Room and Board Contractual Allowance **	$	1,490,139	1,490,139		
4. a. Private-Pay Residents and Other	$	3,002,391	3,002,391		
b. Private-Pay Room and Board Contractual Allowance **	$	32,614	32,614		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	598,021	598,021		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(598,021)	(598,021)		
c. Prescription Drugs - Non-Medicare	$	350,840	350,840		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(350,840)	(350,840)		
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$	2,437	2,437		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(2,437)	(2,437)		
3. a. Physical Therapy - Medicare	$	1,389,824	1,389,824		
b. Physical Therapy - Medicare Contractual Allowance **	$	(1,251,055)	(1,251,055)		
c. Physical Therapy - Non-Medicare	$	790,350	790,350		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(790,350)	(790,350)		
4. a. Speech Therapy - Medicare	$	163,515	163,515		
b. Speech Therapy - Medicare Contractual Allowance **	$	(153,739)	(153,739)		
c. Speech Therapy - Non-Medicare	$	86,880	86,880		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(86,880)	(86,880)		
5. a. Occupational Therapy - Medicare	$	1,354,204	1,354,204		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(1,273,730)	(1,273,730)		
c. Occupational Therapy - Non-Medicare	$	789,125	789,125		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(789,125)	(789,125)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	(2,032)	(2,032)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	11,610,088	11,610,088		
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)*	$	240	240		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$	3,884	3,884		
8. Other (*Specify*)	$				
V. Total Other Revenue (1 thru 8)	$	4,124	4,124		
VI. Total All Revenue (III +V)	$	11,614,212	11,614,212		

* *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	Retroactives	$ (2,032)	$ -	$ -
		$ -	$ -	$ -
		$ -	$ -	$ -
		$ -	$ -	$ -
		$ -	$ -	$ -
		$ -	$ -	$ -
Total Other Resident Revenue		$ (2,032)	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
30/IV5	Interest on A/R	-	$ 240	$ -	$ -
		-	$ -	$ -	$ -
		-	$ -	$ -	$ -
		-	$ -	$ -	$ -
Total Interest Income			$ 240	$ -	$ -

Schedule of Other Revenue

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

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Ce	2442	9/30/2018	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 643,933
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 2,199,182
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 3,955
4 Inventories				$
5. Prepaid Expenses				$ 377,419
a. Prepaid Insurance		153,543		
b. Prepaid Health Insurance		193		
c. Prepaid Tax, Rent and Other		223,683		
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
Wage Enhancement				
Working Capital Reserve				
Renewal & Replacement Fund				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 3,224,489
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	46,637		$ 43,401
	Accum. Depreciation	3,236	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	94,986		$ 21,202
	Accum. Depreciation	73,784	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 644,692
Moveable Equipment Carryforward		617,500		
Project Development		27,192		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 709,295

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

(*Carry Total forward to next page*)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-32 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Ce	2442	9/30/2018	32	37

Account					Amount
				Total Brought Forward:	$ 3,933,784
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)				$ 4,739,343
	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*)				$
	Start Up Costs				
D-8.	***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 4,739,343
D-9.	***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 8,673,127

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2018	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 1,358,956
2. Notes Payable (*itemize*)				$ (68,000)
Due From Related Party		(68,000)		
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*)				$ 437,421
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 8,224
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*)				$ 139,349
		Provider Taxes Due	111,343	
		Accd Health insurance	206	
Acc'd Operating Expenses	26,813			
Acc'd Expense - Sales Tax	987			
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 1,875,950

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

(Carry Total forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-34 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2018	34	37

Account	Amount
Total Brought Forward:	1,875,950
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

Account	Amount
2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date
Working Capital Reserve		NA

Account		Amount
4. Other Long-Term Liabilities (*itemize*)		$ 3,189,979
Notes Payable Related Landlord	3,079,493	
Swap Value	110,486	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 3,189,979
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 5,065,929

Montowese
ACCRUED OPERATING EXP - 2170
September 30, 2018

DESCRIPTION	Amount
Employee Travel	239.40
Maintenance & Repairs	2,850.18
X-Ray Medicare A	218.25
Lab Medicare A	3,782.94
IV Therapy Medicare A	10,404.73
Patient Entertainment	21.24
Payroll Processing	1,371.56
Patient Refund	60.00
Medical Director	3,000.00
Medical Supplies	4,864.40
	26,812.70

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-35 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation C	2442	9/30/2018	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				$ (587,813)
6. Gain or Loss for Period	1/25/2018	thru	9/30/2018	$ 820,011
7. Total Net Worth				$ 3,607,198
C. ***Total Reserves and Net Worth***				$ 3,607,198
D. ***Total Liabilities, Reserves, and Net Worth***				$ 8,673,127

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-36 Rev. 6/95

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Cen	2442	9/30/2018	36	37

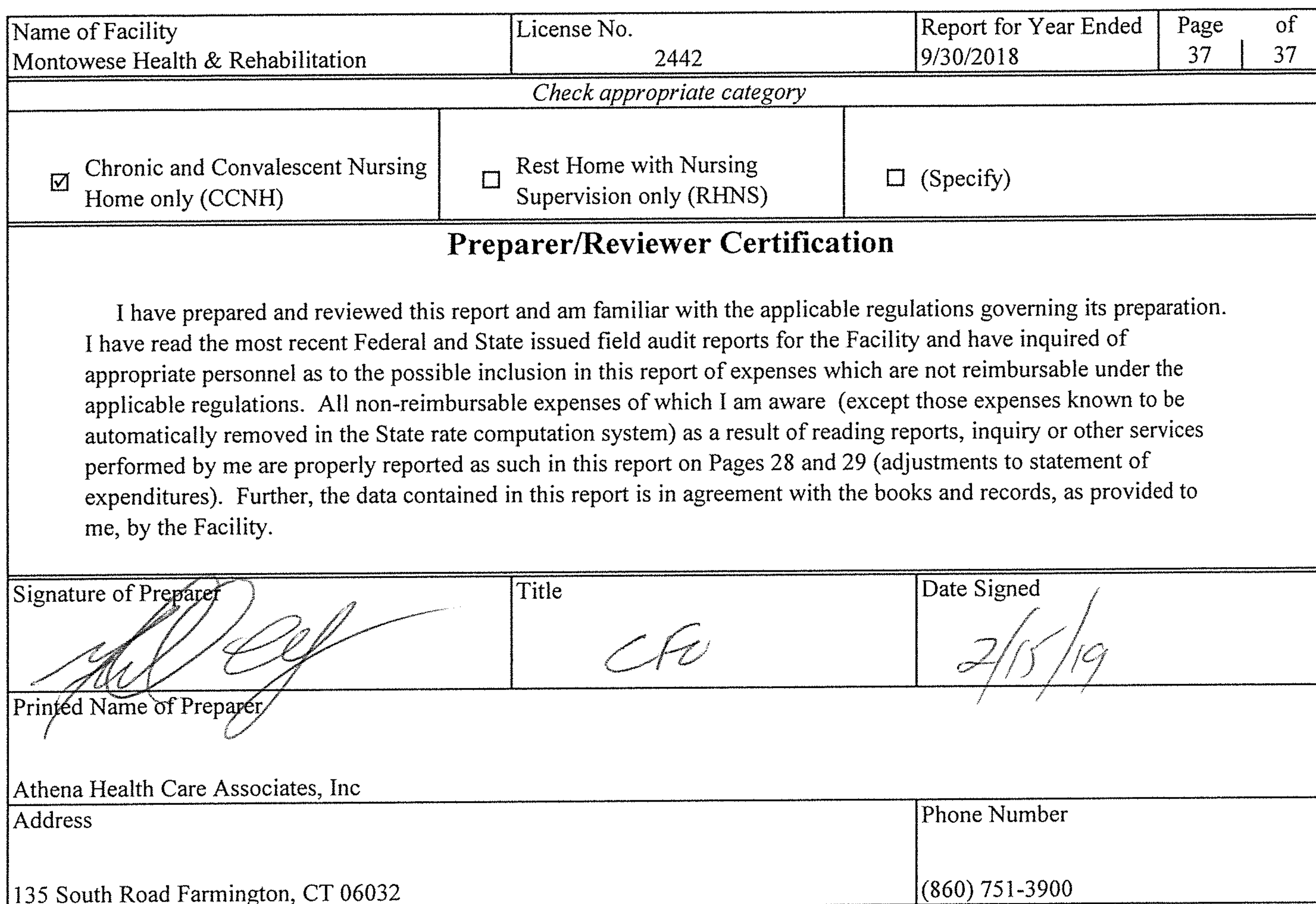
	Account		Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2017	$	
B.	Total Revenue (*From Statement of Revenue Page 30*)	$	11,614,212
C.	Total Expenditures (*From Statement of Expenditures Page 27*)	$	10,794,201
D.	Net Income or Deficit	$	820,011
E.	Balance	$	820,011
F.	Additions 1. Additional Capital Contributed (*itemize*) Partners Capital Contribution 2,787,187		
	2. Other (*itemize*)		
F-3.	Total Additions	$	2,787,187
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*** 09/30/18	$	3,607,198



I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation	2442	9/30/2018	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
[signature]	CFO	2/15/19

Printed Name of Preparer	
Athena Health Care Associates, Inc	
Address	**Phone Number**
135 South Road Farmington, CT 06032	(860) 751-3900