State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2020

Name of Facility (as licensed) Newtown Rehabilitation & Health Care Center		
Address (No. & Street, City, State, Zip Code) 139 Toddy Hill Road, Newtown, CT 06470		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	10207			07-5355

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	10207		

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care Center	10207	9/30/2020	1	37

Administrator's/Owner's Certification

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

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

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

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

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

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Newtown Rehabilitation & Health Care Center	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 139 Toddy Hill Road, Newtown, CT 06470				
Report Prepared By Athena Health Care Associates, Inc.	Phone Number 860 751-3900		Date	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

	Phone No. of Facility	Report for Year Ended	Page	of
	(203) 426-5847	9/30/2020	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Newtown Rehabilitation & Health Care Center	139 Toddy Hill Road, Newtown, CT 06470

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	10207			07-5355

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
Jane Devries		1094

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

Name	License No.:
N/A	

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General Information and Questionnaire
Partners/Members

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

Name of Partners/Members	Business Address	Title	% Owned
Lawrence Santilli	135 South Road, Farmington, CT 06032	Manager	61

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care Cente	10207	9/30/2020	3A	37

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

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

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

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General Information and Questionnaire
Individual Proprietorship

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

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Newtown Landlord CT, LLC	135 South Road, Farmington, CT 06032	○	⊙		Lease of facility	Pg22, Ln9, 10b	747,220	747,220
Athena Health Care Associates, Inc. 401K Plan	135 South Road, Farmington, CT 06032	○	⊙		Facility participates in group 401K plan	Pg 15, ln 1a7		
Athena Captive, LLC	135 South Road, Farmington, CT 06032	○	⊙		Workers compensation captive	Pg 15, ln 1a	125,947	125,947
Miscellaneous facilties	Various	⊙	○	<98%	Interfacility loans	Pg 33, A2		
Athena Health Care Insurance	135 South Road, Farmington, CT 06032	⊙	○	>50%	Self insured employee health insurance	Pg 15, ln 1a5	1,081,216	1,081,216
Procare, LTC	111 Executive Blvd., Farmingdale, NY 11735	⊙	○	>50%	Pharmacy	Pg 20, 5a2	449,436	449,436
Athena Health Care Associates, Inc.	135 South Road, Farmington, CT 06032	⊙	○		see attached			
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

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

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

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

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

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

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

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

Not applicable: No Non-Nursing home cost centers

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Pitney Bowes, 60 Wellington Rd., Milford, CT 06484	○	⊙	Postal equipment	06/01/18	36 months	734	734
Canon Solutions, One Canon Park, Melville, NY 11747	○	⊙	copiers	06/01/18	40 months	2,511	2,511
Canon Solutions, One Canon Park, Melville, NY 11747	○	⊙	copiers	06/01/18	40 months	14,789	14,789
Canon Solutions, One Canon Park, Melville, NY 11747	○	⊙	copiers	06/01/18	40 months	2,999	2,999
Canon Solutions, One Canon Park, Melville, NY 11747	○	⊙	copiers	10/01/18	40 months	3,561	3,561
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ⊙ Yes ○ No **Total ***** 24,594

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

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General Information and Questionnaire
Accounting Basis

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Marcum, L.L.P.	555 Long Wharf Dr., New Haven, CT
2 Marcum, L.L.P.	555 Long Wharf Dr., New Haven, CT
3 Marcum, L.L.P.	555 Long Wharf Dr., New Haven, CT
4	

Services Provided by This Firm (*describe fully*)

1	Financial statement audit-allowed	$ 19,250
2	Medicare Cost Reports-allowed	$ 2,700
3	2018 Tax return - allowed	$ 4,249
4		$

Charge for Services Provided: $ 26,199

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

⊙ Yes ○ No

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Goldman, Gruder & Woods, LLC/Pilicy & Ryan	203 899-8900/203 364-3388
2 Jackson, Lewis, P.C.	914 872-6767
3 Murtha, Cullina, L.L.P.	203 772-7700
4 Reid & Riege, PC	860 278-1150
5 Stephen Woods/ Treasurer, State of CT	203 794-8508

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

1 200 CT Ave., Norwalk, CT/PO Box 5505, Newtown, CT
2 1133 Westchester Ave., W. Harrison, NY
3 265 Church St., New Haven, CT
4 One Financial Plaza, Hartford, CT
5 PO Box 371, Danbury, CT/ 1 School St, Bethel, CT

Services Provided by This Firm (*describe fully*)

1	A/R collections-disallowed	$ 10,148
2	Workman's compensation issue-disallowed	$ 335
3	General administration services-disallowed	$ 1,187
4	Line of credit, banking - disallowed	$ 1,339
5	Conservatorship matters-disallowed	$ 1,659

Charge for Services Provided: $ 14,668

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

⊙ Yes ○ No — Pg 15, Line 1e

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Schedule of Resident Statistics

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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	154	154			154	154						
B. On last day of THIS report period	154	154							154	154		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	134	134			134	134						
B. As of midnight of THIS report period	101	101							101	101		
3. Total Number of Days Care Provided During Period												
A. Medicare	8,902	8,902			7,228	7,228			1,674	1,674		
B. Medicaid (Conn.)	29,111	29,111			22,829	22,829			6,282	6,282		
C. Medicaid (other states)												
D. Private Pay	4,182	4,182			2,998	2,998			1,184	1,184		
E. State SSI for RCH												
F. Other (Specify)	725	725			470	470			255	255		
G. Total Care Days During Period (3A thru F)	42,920	42,920			33,525	33,525			9,395	9,395		
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	56	56			55	55			1	1		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	42,976	42,976			33,580	33,580			9,396	9,396		

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Schedule of Resident Statistics (Cont'd)

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

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	8	71		13		9		
Per Diem Rate								
a. One bed rm.	579.15	263.00		556.00		395.00		
b. Two bed rms.	579.15	263.00		507.00		395.00		
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	507	507		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	225	225		
2. Restorative Treatments				
C. Other	1,507	1,507		
D. ***Total Physical Therapy Treatments***	2,239	2,239		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	110	110		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	24	24		
2. Restorative Treatments				
C. Other	366	366		
D. ***Total Speech Therapy Treatments***	500	500		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	624	624		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	270	270		
2. Restorative Treatments				
C. Other	1,697	1,697		
D. ***Total Occupational Therapy Treatments***	2,591	2,591		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care Center	10207	9/30/2020	10	37

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	164,203	2,243				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	354,915	14,016				
5. Dietary Service						
a. Head Dietitian	72,506	1,711				
b. Food Service Supervisor	50,061	1,318				
c. Dietary Workers	610,567	30,318				
6. Housekeeping Service						
a. Head Housekeeper	68,738	2,494				
b. Other Housekeeping Workers	280,510	16,761				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	85,246	2,234				
b. Other Maintenance Workers	65,187	2,188				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	787	47				
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	246,238	4,199				
b. RN						
1. Direct Care	785,413	16,644				
2. Administrative**	626,993	18,090				
c. LPN						
1. Direct Care	1,454,751	41,588				
2. Administrative**						
d. Aides and Attendants	2,353,753	110,589				
e. Physical Therapists	608,175	15,693				
f. Speech Therapists	161,115	3,412				
g. Occupational Therapists	381,989	9,809				
h. Recreation Workers	238,388	10,157				
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	297,641	8,304				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	8,907,176	311,815				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
N/A										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
N/A										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Jane Devries 04/05/20-09/30/20	73,858					1,067	A2			
Theresa Lebel 03/8/20-04/11/20	14,000					200	A2	Laurel Ridge Health Care, 642 Danbury Rd, Ridgefield, CT	136	8,483
John Horstman 10/1/19-3/9/20	76,345					976	A2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care Center	10207	9/30/2020	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	19,707	154				
3. Pharmacist	15,710	235				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	51,871	483				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	2,615	21				
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	5,126	14				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	198,098	1,888				
2. Administrative***	498	4				
b. LPN						
1. Direct Care	226,268	4,093				
2. Administrative***						
c. Aides	96,478	3,595				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	616,371	10,487				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care Center	10207	9/30/2020	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
SDX Dysphagia Experts, 21 Waterville Rd., Avon, CT	Speech therapy	○	⊙	
Nurse Network, access Capital, 405 Park Ave., New York, NY	Nurse pool	○	⊙	
Bridgeport Hospital, 267 Grant St., Bridgeport, CT	Radiology	○	⊙	
Procare, LTC, 111 Executive Blvd., Farmingdale, NY	Pharmacist	⊙	○	Common Owners: minority interest
CT Orthopedic Specialist, 2408 Whitney Ave., Hamden, CT	Orthopedics	○	⊙	
Robert Larosa, DDS, 375 Main St., Woodbury, CT	Dental Consulting	○	⊙	
Health Drive Dental Group, 100 Crossing Blvd., Framingham, MA	Dental Consulting	○	⊙	
Quotidian, 52 Seniff Rd., Washington, CT	Medical Director	○	⊙	
Ortho CT, PC, 2 Riverview Dr., Danbury, CT	Orthopedics	○	⊙	
Orthopedic Specialists of CT, 60 Old New Milford Rd., Brookfieldl, CT	Orthopedics	○	⊙	
Ortho Connecticut, PO Box 26303, Oklahoma City, OK	Orthopedics	○	⊙	
Brigham & Womens Physicians, PO Box 414205, Boston, MA	Radiology	○	⊙	
Yale New Haven Hospital, PO Box 780406, Philadelphia, PA	Radiology	○	⊙	
NOA Diagnostics, 6851 Jericho Tpke., Syosset, NY	Radiology	○	⊙	
Worldwide Staff, 2222 Sedwick Rd., Durham, NC	Nurse pool	○	⊙	
The Nurse Network, LLC, PO Box 982, Southington, CT	Nurse pool	○	⊙	
AAA Nursing Care, LLC, 3303 Main St., Stratford, CT	Nurse pool	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care Center	10207	9/30/2020	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	125,947	125,947		
2. Disability Insurance	$				
3. Unemployment Insurance	$	105,298	105,298		
4. Social Security (F.I.C.A.)	$	662,007	662,007		
5. Health Insurance	$	948,235	948,235		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	50,713	50,713		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans forOwners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	154,029	154,029		
d. Accounting and Auditing	$	26,199	26,199		
e. Legal (*Services should be fully described on Page 7)*	$	14,668	14,668		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	64,672	64,672		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	15,322	15,322		
2. Cellular Phones	$	6,722	6,722		
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*	$	2,500	2,500		
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	716,235	716,235		
Subtotal	$	2,892,547	2,892,547		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care Center	10207	9/30/2020	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,892,547	2,892,547		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	183	183		
3. Gifts to Staff and Residents	$	16,977	16,977		
4. Employee Travel	$	1,036	1,036		
5. Education Expenses Related to Seminars and Conventions	$	4,264	4,264		
6. Automobile Expense (*not purchase or depreciation*)	$	2,509	2,509		
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	29,992	29,992		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	6,783	6,783		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	7,997	7,997		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	12,826	12,826		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	1,250	1,250		
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**	$	342,884	342,884		
13. Other (*Specify*)	$	130,451	130,451		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	3,449,699	3,449,699		

* 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	$ 6,783		
Total Other Advertising	$ 6,783	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 12,826		
Total Dues	$ 12,826	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank charges	$ 28,601		
Payroll processing fees	$ 24,371		
Employee physicals	$ 15,298		
Energy audit	$ 4,467		
Data Processing fees	$ 55,204		
Licenses	$ 2,510		
Total Other Administrative and General	$ 130,451	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Newtown Rehabilitation & Health Care C	10207	9/30/2020	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 Association, Inc.	519,521		See below
135 South Road	location of above		
Farmington, CT 06032	342,884	Admin/Genl 66%	Pg 16, Line 12
	83,123	Indirect 16%	Pg 18, Line 2C
	93,514	Direct 18%	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.**

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

Name of Facility	License No.	Report for Year Ended	Page of
Newtown Rehabilitation & Health Care Center	10207	9/30/2020	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	332,001	332,001		
2. Non-Food Supplies	$	45,080	45,080		
3. Other (*Specify*)_____	$	393	393		
Dishes & utensils					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____	$	83,123	83,123		
Management services					
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	460,597	460,597		

2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	352	352		

G.	Is cost of employee meals included in 2D?	○ Yes	⊙ No	
H.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	⊙ Yes	○ No	If yes, specify cost. $914
K.	Is any revenue collected from these people?	⊙ Yes	○ No	If yes, specify amt. $43,799
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			Pg 30, IV 1
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	○ Yes	⊙ No	If yes, specify cost.
N.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

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

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CSP-19 Rev. 9/2018

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
Newtown Rehabilitation & Health Care Center	10207	9/30/2020	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $	1,650	1,650		
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	145,604	145,604		
c. Other (*Specify*) Supplies	$	5,054	5,054		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	152,308	152,308		

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care Center	10207	9/30/2020	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	53,849	53,849		
b. Purchased Services (*by contract other than through Management Services*)	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	53,849	53,849		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Procare, LTC		$	433,806	433,806		
b. Medicine Cabinet Drugs		$	2,969	2,969		
c. Medical and Therapeutic Supplies		$	379,883	379,883		
d. Ambulance/Limousine***		$	2,461	2,461		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	6,914	6,914		
f. X-rays and Related Radiological Procedures***		$	28,392	28,392		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	174,171	174,171		
i. Recreation		$	17,616	17,616		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	183,474	183,474		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	1,229,686	1,229,686		

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

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Management fee-direct	$ 93,514		
Medical equipment rentals-Medicaid	$ 39,806		
Physical therapy supplies	$ 10,641		
Oxygen concentrator rentals	$ 18,135		
Cable TV fees	$ 21,378		
Total Other Resident Care	$ 183,474	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care Center	10207	9/30/2020	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Procare LTC	111 Executive Blvd, Farmingdale, NY 11735	⊙	○	Common owners: minority interest	Pharmacy	449,436			20	5a2
JM Construction	PO Box 3873, Danbury, CT 06813	○	⊙		Snowplowing	23,813			22	6f
JM Construction	PO Box 3873, Danbury, CT 06813	○	⊙		Landscaping	15,128			22	6f
R & P Tree Work	2nd Fl., Danbury, CT 06810	○	⊙		Landscaping	11,206			22	6f
Air Temp Mechanical Services, Inc.	Drive, Southington, CT 06489	○	⊙		Mechanical Repair	23,599			22	6a
Eastern Water Solutions	3 Benson Road, Oxford, CT 06478	○	⊙		Sewage system repairs	13,288			22	6a
All American Waste	PO Box 630, East Windsor, CT 06088	○	⊙		Rubbish removal	31,493			22	6f
Facilities Comp	221 West Main Street, Plantsville, CT 06479	○	⊙		Facility inspections	17,356			22	6a
ADP	PO Box 842875, Boston, MA 02284	○	⊙		Payroll services	19,195			16	m13
Pointclickcare Technologies, Inc.	PO Box 674802, Detroit, MI 48267	○	⊙		Data processing services	26,183			16	m13
OTIS Elevator	PO Box 73579, Chicago, IL 60673	○	⊙		Mechanical Repair	12,216			16	m13
Wind River Environmental,LLC	Marlborough, MA 01752	○	⊙		Sewage system servicing	14,977			16	m13
		○	⊙							
		○	⊙							

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Newtown Rehabilitation & Health Care Cente	10207	9/30/2020	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	144,246	144,246		
b. Heat	$	104,134	104,134		
c. Light & Power	$	163,718	163,718		
d. Water	$	9,693	9,693		
e. Equipment Lease (*Provide detail on page 6*)	$	24,594	24,594		
f. Other (*itemize*)	$	95,764	95,764		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	542,149	542,149		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$				
d. Movable Equipment	$	185,742	185,742		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	185,742	185,742		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$	266,235	266,235		
b. Mortgage Expense	$				
c. Leasehold Improvements	$	42,037	42,037		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	308,272	308,272		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	747,220	747,220		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	281,525	281,525		
c. Personal property taxes	$	20,133	20,133		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,542,892	1,542,892		

* 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	$ 26,334		
Rubbish removal	$ 31,493		
Snow removal	$ 23,813		
Supplies	$ 14,124		
Total Other Repairs and Maintenance	$ 95,764	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care Center	10207	9/30/2020	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.	yes		6	2018	30,000		30,000	9,000	S/L	5	6,000	
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			9	2019	817,434		817,434	255,815	S/L	various	175,479	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2020	70,652						4,263	
D-3. Subtotal												185,742
E. ***Total Depreciation***												185,742

Schedule of Land Improvements Acquired during this report peri

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

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

Schedule of Building Improvements Acquired during this report peri

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

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

Schedule of Non-Movable Equipment Acquired during this report peri

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

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

Schedule of Movable Equipment Acquired during this report perio

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Oct-19	Electric Bed packages (15)	$ 26,409	12	$ 1,100	
Oct-19	Electric Bed packages (1)	$ 1,918	12	$ 80	
Dec-19	32" TV's (7)	$ 1,734	5	$ 173	
Apr-20	Optiguard Door Protection system	$ 7,884	10	$ 394	
May-20	SatelliteTV equipment	$ 15,094	10	$ 755	
Jun-20	Additional for asset #57 -camera system	$ 2,530	5	$ 253	
Jun-20	Hik vision Camera System	$ 5,977	5	$ 598	
Jul-20	Samsun & apple tablets and ipods	$ 3,898	3	$ 650	
Aug-20	Mixer with floor stand	$ 5,208	10	$ 260	
Total additions for Movable Equipmen		$ 70,652		$ 4,263	*
Deletions:					
Total deletions for Movable Equipmen		$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report perio

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Oct-19	Prep work for Nurse's station	$ 26,706	10	$ 1,335	
Oct-19	Wastewater pumps-1st billing	$ 4,065	10	$ 203	
Oct-19	Wastewater pumps-2nd billing	$ 2,710	10	$ 136	
Oct-19	Wastewater pumps-final billing	$ 6,677	10	$ 334	
Nov-19	Nursing station design	$ 914	10	$ 46	
Nov-19	Masonry	$ 45,500	5	$ 4,550	
Dec-19	Catch basin	$ 20,000	15	$ 667	
Dec-19	Parking lot asphalt	$ 2,100	15	$ 70	
Dec-19	Satellite tv cable lines	$ 3,971	10	$ 199	
May-20	Honeywell Jace AX controller for A/C	$ 15,497	10	$ 775	
Jun-20	Electricity installation for elevator & one nurs unit	$ 22,892	20	$ 572	
Jun-20	Well # 7 pump & wiring	$ 2,678	10	$ 134	
Jun-20	Heat exchanger for boiler	$ 2,251	10	$ 113	
Jul-20	Painting window sills, crown moulding, bldg area.	$ 82,000	5	$ 8,200	
Jul-20	120 gallon pressure buffering tank	$ 4,162	20	$ 104	
Jul-20	Wiring for HVAC unit -addition to inv #16572	$ 2,818	20	$ 70	
Aug-20	Elevator room remodel-carpentry	$ 8,500	15	$ 283	
Sep-20	Roof chiller compressor module	$ 2,047	10	$ 102	
Total additions for Leasehold Improvemer		$ 255,488		$ 17,893	*
Deletions:					

Total deletions for Leasehold Improvemen		$ -		$ -

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

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care Center	10207	9/30/2020	24	37

Item	Date of Acquisition Month	Date of Acquisition Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1. Start-up costs	6	2018	10 years	2,554,207	345,885			266,235	
2.									
3.									
A-4. Subtotal									266,235
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	9	2019	various	337,592	18,325	S/L	variou	24,144	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2020		255,488		S/L	variou	17,893	
C-4. Subtotal									42,037
D. ***Total Amortization***									308,272

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Car	10207	9/30/2020	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	06/01/18
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	154
6. Square Footage	
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	HUD			
b. Date Mortgage Obtained	06/01/18			
c. Interest Rate for the Cost Year	618.00%			
d. Term of Mortgage (number of years)	4 years			
e. Amount of Principal Borrowed	13,500,000			
f. Principal balance outstanding as of _____	13,082,048			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Newtown Rehabilitation & Health Car	10207	9/30/2020	26 | 37

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

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Newtown Rehabilitation & Health	10207	9/30/2020	27 | 37

Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment 1. Automotive Equipment		$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (*Specify*)		$	4,883	4,883		
A. Item phone system	Rate	Amount				
Lender Var Tech						
Address of Lender PO Box 10306, Des Moines, IA						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		$	4,883	4,883		
12. D. Other Interest Expense (*Specify*) Vendor interest		$	20,938	20,938		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)		$	25,821	25,821		
14. Insurance						
a. Insurance on Property (buildings only)		$	109,079	109,079		
b. Insurance on Automobiles		$	3,231	3,231		
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)***		$	112,310	112,310		
15. ***Total All Expenditures (A-13 thru C-14)***		$	17,092,858	17,092,858		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Newtown Rehabilitation & Health Care Center	10207	9/30/2020	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $	11,628	11,628		
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $	2,615	2,615		
6.			Occupational Therapy $	381,989	381,989		
7.			Other - See attached Schedule $	498	498		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $	154,029	154,029		
10.			Accounting $				
10a.			Legal $	14,668	14,668		
11.			Telephone $				
12.			Cellular Telephone $	6,002	6,002		
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $	16,977	16,977		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.			Unallowable Advertising * $	6,783	6,783		
19.			Income Tax / Corporate Business Tax $	2,500	2,500		
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $	218,968	218,968		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	28,601	28,601		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $	42,885	42,885		
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	888,143	888,143		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	12m	Marketing activities	$ 11,628		
Total Other Salaries Adjustment			$ 11,628	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B11a2	Nursing consultant	$ 498		
Total Other Fees Adjustments			$ 498	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M13	Bank fees	$ 28,601		
Total Other A&G Adjustments			$ 28,601	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Newtown Rehabilitation & Health Care Center	10207	9/30/2020	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	888,143	888,143		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs $	433,806	433,806		
28.			Ambulance/Limousine $	2,461	2,461		
29.			X-rays, etc $	28,392	28,392		
30.			Laboratory $	174,171	174,171		
31.			Medical Supplies $	15,860	15,860		
32.			Oxygen (non emergency) $	6,914	6,914		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	39,806	39,806		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $	139,851	139,851		
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Other - Indirect $				
43.			Interest Income on Account Rec. $	208	208		
44.			Other - Miscellaneous Administrative $	17,778	17,778		
45.			Management Fees Direct $				
46.			Management Fees Indirect $				
47.			Other - Direct $				
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
49.			***Total Amount of Decrease (Items 1 - 48)*** $	1,747,390	1,747,390		

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

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Medical equipment rental-Medicaid	$ 39,806		
Total Other Ancillary Costs			$ 39,806	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7f	Moveable equipment depreciation carryforward AJE	$ 139,851		
Total Excess Movable Equipment Depreciation			$ 139,851	$ -	$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

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

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	CableTV	$ 17,778		
Total Other Adjustments			$ 17,778	$ -	$ -

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care Ce	10207	9/30/2020	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	14,574,906	14,574,906		
b. Medicaid Room and Board Contractual Allowance **	$	(6,891,587)	(6,891,587)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	3,002,954	3,002,954		
b. Medicare Room and Board Contractual Allowance **	$	1,721,743	1,721,743		
4. a. Private-Pay Residents and Other	$	3,887,798	3,887,798		
b. Private-Pay Room and Board Contractual Allowance **	$	(401,182)	(401,182)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	251,306	251,306		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(226,773)	(226,773)		
c. Prescription Drugs - Non-Medicare	$	182,087	182,087		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(182,087)	(182,087)		
2. a. Medical Supplies - Medicare	$	2,160	2,160		
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$	188	188		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(188)	(188)		
3. a. Physical Therapy - Medicare	$	1,031,388	1,031,388		
b. Physical Therapy - Medicare Contractual Allowance **	$	(815,141)	(815,141)		
c. Physical Therapy - Non-Medicare	$	379,760	379,760		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(374,110)	(374,110)		
4. a. Speech Therapy - Medicare	$	396,488	396,488		
b. Speech Therapy - Medicare Contractual Allowance **	$	(325,303)	(325,303)		
c. Speech Therapy - Non-Medicare	$	183,875	183,875		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(180,575)	(180,575)		
5. a. Occupational Therapy - Medicare	$	994,100	994,100		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(816,218)	(816,218)		
c. Occupational Therapy - Non-Medicare	$	400,690	400,690		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(395,040)	(395,040)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	367,192	367,192		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	16,768,431	16,768,431		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	43,799	43,799		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	208	208		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	32,761	32,761		
V. Total Other Revenue (1 thru 8)	$	76,768	76,768		
VI. Total All Revenue (III +V)	$	16,845,199	16,845,199		

* *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	$ 39,511		
	Miscellaneous revenue from CRF funding	$ 327,679		
	Rounding	$ 2		
Total Other Resident Revenue		$ 367,192	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Pg 31, L A1	Interest on A/R		$ 208		
Total Interest Income			$ 208	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
N/A	Bad debt recoveries	$ 29,350		
	Nursing supply rebate	$ 3,411		
Total Other Revenue		$ 32,761	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care	10207	9/30/2020	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 797,237
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,587,322
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ (237,675)
4 Inventories				$ 22,274
5. Prepaid Expenses				$ 131,414
a. Prepaid Insurance		124,397		
b. Prepaid Interest		256		
c. Prepaid Expenses-other		6,761		
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$ (851,858)
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,448,714
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	593,080		$ 532,718
	Accum. Depreciation	60,362	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	888,086		$ 452,529
	Accum. Depreciation	435,557	Net	
7. Motor Vehicles	*Historical Cost	30,000		$ 15,000
	Accum. Depreciation	15,000	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 376,207
See Schedule		376,207		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 1,376,454

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			$ -

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

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

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

Page Ref	Line Ref	Description	
31	B9	Excluded moveable equipment	$ 376,207
Total Other Other Fixed Assets (Itemize)			$ 376,207

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

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

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

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care	10207	9/30/2020	32	37

Account					Amount
			Total Brought Forward:	$	2,825,168
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	2,554,207			
	Accum. Depreciation	612,120	Net	$	1,942,087
4. Goodwill (Purchased Only)				$	97,350
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*)				$	732,452
Deposits for utilities		6,479			
Project Development		725,973			
See Schedule					
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$	2,771,889
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$	5,597,057

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care Center	10207	9/30/2020	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 2,096,425
	2. Notes Payable (*itemize*)				$ (65,818)
	Due from related party	(65,818)			
	See Schedule				
	3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
	Name of Lender	Purpose	Amount	Date Due	
	4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 332,496
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 285,468
	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*)				$ 22,089
	11. Accrued Income Taxes*				$
	12. Other Current Liabilities (*itemize*)				$ 140,627
	Accrued Health insurance	283	Accrued real estate tax	(61,532)	
	Accrued operating expenses	39,384			
	Accrued CT sales tax	176			
	Due to Medicaid-provider tax	162,316	See Schedule		
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 2,811,287

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care Cen	10207	9/30/2020	34	37

Account				Amount
		Total Brought Forward:		2,811,287
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (*itemize*)				$ 44,471
Name of Lender	Purpose	Amount	Date Due	
	equipment lease	31,907		
	equipment lease	12,564		
2. Mortgages Payable				$
3. Loans from Owners or Related Parties (*itemize*)				$ 2,908,386
Name and Address of Lender	Amount	Loan Date		
Due to related party	3,988,573			
Due to affiliate	(1,080,187)			
4. Other Long-Term Liabilities (*itemize*)				$ 3,993
Note Payable-McKesson	3,993			
See Schedule				
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ 2,956,850
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 5,768,137

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

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care	10207	9/30/2020	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$ 500,000
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (780,234)
	6. Gain or Loss for Period 10/1/2019 thru 9/30/2020	$ (247,659)
	7. Total Net Worth	$ (527,893)
C.	***Total Reserves and Net Worth***	$ (527,893)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 5,240,244

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care (	10207	9/30/2020	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2019			$ (148,396)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 16,845,199
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 17,092,858
D.	Net Income or Deficit			$ (247,659)
E.	Balance			$ (396,055)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Health insurance accrual 2018	(15,671)		
	Lease expense 2018	(1,691)		
	Start up cost amortization 2018	(79,650)		
	Start up cost amortization 2020	(27,286)		
	2. Other (*itemize*)			
	Bring start up costs into balance	(7,540)		
F-3.	Total Additions			$ (131,838)
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose	Amount		
	3. Total Deductions			$
H.	***Balance at End of Period*** 09/30/20			$ (527,893)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-37 Rev. 9/2002

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care	10207	9/30/2020	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
Athena Health Care Associates, Inc.

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

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number

Contact Email Address