State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2022

Name of Facility (as licensed) Montowese Health & Rehabilitation Center		
Address (No. & Street, City, State, Zip Code) 163 Quinnipiac Avenue, North Haven, CT 06473		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2021	Report for Year Ending 9/30/2022	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2442			07-5017

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	000010157		

For Department Use Only

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

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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	9/30/2022	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Montowese Health & Rehabilitation Center [facility name], for the cost report period beginning October 1, 2021 and ending September 30, 2022, 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) Patrick McDonnell			Printed Name (Owner) Lawrence Santilli	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Montowese Health & Rehabilitation Center	Period Covered:		From 10/1/2021	To 9/30/2022
Address of Facility 163 Quinnipiac Avenue, North Haven, CT 06473				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900		Date 2/12/2021	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-624-3303	9/30/2022	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			07-5017

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.:	
Patrick McDonnell		1574

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

Name	License No.:
Not Applicable	

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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 G Santilli	135 South Rd Farmington, CT 06032	President	0.62

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General Information and Questionnaire
Corporate Owners

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

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

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Not Applicable			
Names of Stockholders Owning at Least 10% of Shares			

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General Information and Questionnaire
Individual Proprietorship

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

Owner(s) of Facility
Not Applicable

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General Information and Questionnaire
Related Parties*

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Montowese Landlord LLC	135 South Rd, Farmington, CT 06032	○	⊙		Lease of Property	Pg 22 L9	246,888	246,888
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		40,897	40,897
Procare Pharmacy	111 Executive Blvd, Farmingdale, NY 11735	⊙	○	>50%	Pharmacy Services	pg 20 5a2, 5b,	830,057	830,057
Procare Pharmacy	111 Executive Blvd, Farmingdale, NY 11735	⊙	○	>50%	Notes Payable	Pg 34 B4, Pg 27 12D	195,727	195,727
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

* 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.

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.

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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, PO Box 371887, Pittsburgh, PA 15250	○	⊙	Mail Machine	01/31/18	63	2,126	1,594
Xerox, PO Box 202882, Dallas, TX 75320-2882	○	⊙	Copier	12/08/20	36	16,667	16,565
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total ***** 18,159

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

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General Information and Questionnaire
Accounting Basis

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

◉ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

	Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1	Marcum, LLP	185 Asylum St, 17th Floor, Hartford, CT 06103
2	Marcum, LLP	185 Asylum St, 17th Floor, Hartford, CT 06103
3	CJLC LLC	225 Pitkin St, East Hartford, CT 06108
4		

Services Provided by This Firm (*describe fully*)

1	Audit & Tax 2021: Allow	$ 13,895
2	Medicare Cost Report	$ 2,730
3	2022 Audit: Disallow	$ 15,000
4		$
		Charge for Services Provided
		$ 31,625

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

◉ Yes ○ No Pg 15, Line1d

Legal Services Information

	Name of Legal Firm or Independent Attorney	Telephone Number
1	Murtha Cullina	203-772-7700
2	Goldman, Gruder & Woods/Pilicy & Ryan	203-899-8900
3	Garrison, Levin-Epstein, Fitzberal & Pirrottie/V Mancini/Dorthea Warner	
4	Jackson Lewis PC	914-872-8060
5		

	Address (*No. & Street, City, State, Zip Code*)
1	265 Church Street, New Haven, CT 06510
2	200 Connecticut Avenue, Norwalk, CT 06854
3	
4	44 South Broadway 14th Fl, White Plains, NY 10601
5	

Services Provided by This Firm (*describe fully*)

1	Annual Reports & Audit Letter: Allow	$ 342
2	Collections: Disallow	$ 11,626
3	Employee Matters: Disallow	$ 21,500
4	Employee Matters: Disallow	$ 8,241
5		$
		Charge for Services Provided
		$ 41,709

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

◉ Yes ○ No Pg 15, Line1e

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	120	120			120	120						
B. On last day of THIS report period	120	120							120	120		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	116	116			116	116						
B. As of midnight of THIS report period	107	107							107	107		
3. Total Number of Days Care Provided During Period												
A. Medicare	14,218	14,218			10,621	10,621			3,597	3,597		
B. Medicaid (Conn.)	21,309	21,309			15,722	15,722			5,587	5,587		
C. Medicaid (other states)												
D. Private Pay	973	973			809	809			164	164		
E. State SSI for RCH												
F. Other (Specify)	1,546	1,546			1,097	1,097			449	449		
G. Total Care Days During Period (3A thru F)	38,046	38,046			28,249	28,249			9,797	9,797		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	1	1							1	1		
B. Other Bed Reserve Days	3	3			3	3						
5. ***Total Resident Days*** **(3G + 4A + 4B)**	38,050	38,050			28,252	28,252			9,798	9,798		

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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	24	62		2		19		
Per Diem Rate								
a. One bed rm.	604.91	289.85		630.00		419.32		
b. Two bed rms.	604.91	289.85		580.00		419.32		
c. Three or more bed rms.	604.91	289.85		530.00		419.32		

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	18,245	18,245		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	4,618	4,618		
2. Restorative Treatments				
C. Other	35,899	35,899		
D. ***Total Physical Therapy Treatments***	58,762	58,762		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	2,265	2,265		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	702	702		
2. Restorative Treatments				
C. Other	2,646	2,646		
D. ***Total Speech Therapy Treatments***	5,613	5,613		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	16,457	16,457		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	4,803	4,803		
2. Restorative Treatments				
C. Other	35,506	35,506		
D. ***Total Occupational Therapy Treatments***	56,766	56,766		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	161,988	2,105				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	370,713	14,029				
5. Dietary Service						
a. Head Dietitian	87,974	2,098				
b. Food Service Supervisor	81,921	2,117				
c. Dietary Workers	460,126	25,608				
6. Housekeeping Service						
a. Head Housekeeper	73,553	2,231				
b. Other Housekeeping Workers	403,462	24,583				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	80,909	2,154				
b. Other Maintenance Workers	93,298	4,359				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	108,294	6,681				
9. Barber and Beautician Services						
10. Protective Services	48,531	2,844				
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	214,949	3,072				
b. RN						
1. Direct Care	339,430	6,591				
2. Administrative**	1,023,335	28,255				
c. LPN						
1. Direct Care	1,642,821	39,966				
2. Administrative**						
d. Aides and Attendants	1,550,887	67,686				
e. Physical Therapists	1,222,376	30,170				
f. Speech Therapists	222,112	5,326				
g. Occupational Therapists	1,035,547	25,113				
h. Recreation Workers	194,969	7,696				
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	500,782	16,165				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	9,917,977	318,849				

* 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										
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.

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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
Montowese Health & Rehabilitation Center	2442	9/30/2022	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* **										
Donna C. Orefice 10/1/21-12/19/21	29,789			Health & Life Insurance, Payroll Taxes	Day to day operations if the nursing home facility	429	A2			
Patrick McDonnell 12/20/21-9/30/22	132,199			Health & Life Insurance, Payroll Taxes	Day to day operations if the nursing home facility	1,676	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
Montowese Health & Rehabilitation Center	2442	9/30/2022	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	(810)					
3. Pharmacist	16,314	453				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	76,000	231				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	161					
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	6,900	19				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	266,794	2,437				
2. Administrative***						
b. LPN						
1. Direct Care	827,465	9,811				
2. Administrative***						
c. Aides	1,296,991	26,550				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	2,489,815	39,501				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2022	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Dr. Anuruddha Walaliyadda, 12 Cooke Road, Wallingford, CT 06492	Physician-Medical Director	○	⊙	
Dr. Dharini Sun, 2690 Whitey Avenue, Hamden, CT 06518	Physician-Medical Director	○	⊙	
Masstex, 3 Electronics Ave, Suite 210, Danvers, MA 01923	Speech Therapy	○	⊙	
Norton & Associates, 97 Elm St, Cohasset, MA 02025	RN, LPN, C.N.A. Pool	○	⊙	
Solomon Page Staffing Solutions, 260 Madison Ave 4th Fl, New York, NY 10016	RN, LPN, C.N.A. Pool	○	⊙	
Mas Medical Staffing, 156 Harvey Rd, Londonderry, NH 03053	RN, LPN, C.N.A. Pool	○	⊙	
SDX Dysphagia Experts, 21 Waterville Rd, Avon, CT 06001	Speech Therapy	○	⊙	
Nurse Network, 653 Main St, Plantsville, CT 06479	RN, LPN, C.N.A. Pool	○	⊙	
Procare LTC Pharmacy, 110 Bi-County Blvd, Ste 121, Farmingdale, NY 11735	Pharmacist	⊙	○	Common Owners: Minority Interest
Marvel Medical Staffing, 156 Harvey Rd, Londonderry, NH 03053	LPN	○	⊙	
Prime Time Healthcare, PO Box 3544, Omaha, NE 68103	LPN, C.N.A. Pool	○	⊙	
Five Star Care, 410 Melville Ave, Lakewood, NJ 08701	LPN, C.N.A. Pool	○	⊙	
Sambacare, 410 Melville Ave, Lakewood, NJ 08701	LPN, C.N.A. Pool	○	⊙	
Paramount Healthcare Services, Inc, 3 Courthouse Lane, Unit 2, Chelmsford, MA 01824	C.N.A. Pool	○	⊙	
Worldwide Staffing, 2222 Wedwick Rd, Nurham, NC 27713	LPN, C.N.A. Pool	○	⊙	
Fusion Medical, PO Box 30131, Omaha, NE 68103	C.N.A. 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
Montowese Health & Rehabilitation Center	2442	9/30/2022	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	281,696	281,696		
2. Disability Insurance	$				
3. Unemployment Insurance	$	101,501	101,501		
4. Social Security (F.I.C.A.)	$	809,660	809,660		
5. Health Insurance	$	941,740	941,740		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	57,141	57,141		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	60,701	60,701		
d. Accounting and Auditing	$	31,625	31,625		
e. Legal (*Services should be fully described on Page 7)*	$	41,709	41,709		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	64,760	64,760		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	13,527	13,527		
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	$	500,949	500,949		
Subtotal	$	2,905,009	2,905,009		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2022	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,905,009	2,905,009		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	3,680	3,680		
3. Gifts to Staff and Residents	$	11,967	11,967		
4. Employee Travel	$	1,093	1,093		
5. Education Expenses Related to Seminars and Conventions	$	4,448	4,448		
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*)	$	12,120	12,120		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	3,400	3,400		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	4,024	4,024		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	8,871	8,871		
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**	$				
13. Other (*Specify*) See Attached Schedule	$	123,953	123,953		
C-14 Total Administrative & General Expenditures	$	3,079,815	3,079,815		

* 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	$ 3,400		
Total Other Advertising	$ 3,400	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF Dues	$ 8,871		
Total Dues	$ 8,871	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Facility License	$ 1,040		
Bank Charges	$ 16,029		
Payroll Processing Fees	$ 26,792		
Employee Physicals/Background Checks	$ 9,059		
Data Processing/ Software Maint. Fees	$ 51,808		
Other Professional Fees	$ 19,225		
Total Other Administrative and General	$ 123,953	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health & Rehabilitation Cent	2442	9/30/2022	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		Contract Attached to a Prior Year	See Below
Allocation of the above		Admin/Gen 66%	Pg 16, Line 12
Allocation of the above		Indirect 16%	Pg 20 Line 5k
Allocation of the above		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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CSP-18 Rev. 9/2018

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	9/30/2022	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	340,405	340,405		
2. Non-Food Supplies	$	32,212	32,212		
3. Other (*Specify*) Dishes	$	2,962	2,962		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	375,579	375,579		

		Total	CCNH	RHNS	(Specify)
2E.	Dietary Questionnaire				
F.	Resident Meals: Total no. of meals served per day:*	313	313		

G.	Is cost of employee meals included in 2D?	⊙ Yes	○ No		
H.	Did you receive revenue from employees?	⊙ Yes	○ No	If yes, specify amt.	$753
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				Pg 18 2a1
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	○ Yes	⊙ No	If yes, specify cost.	
K.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.	
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	○ Yes	⊙ No	If yes, specify cost.	
N.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.	
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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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 Montowese Health & Rehabilitation Center	License No. 2442	Report for Year Ended 9/30/2022		Page 19 | of 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. $	22,624	22,624		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*) Supplies	$	1,442	1,442		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	24,066	24,066		

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2022	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.	$	63,485	63,485		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	63,485	63,485		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Procare		$	855,921	855,921		
b. Medicine Cabinet Drugs		$	4,246	4,246		
c. Medical and Therapeutic Supplies		$	362,099	362,099		
d. Ambulance/Limousine***		$	24,243	24,243		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	33,977	33,977		
f. X-rays and Related Radiological Procedures***		$	35,028	35,028		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	57,994	57,994		
i. Recreation		$	18,766	18,766		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	174,162	174,162		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	1,566,436	1,566,436		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Cable TV	$ 36,306		
Medical Equip Rentals-Other	$ 35,267		
Physical Therapy Supplies	$ 16,952		
Occupational Therapy Supplies	$ 2,077		
Oxygen Equipment Rentals	$ 33,201		
Medical Equip Rentals-Other	$ 50,359		
Total Other Resident Care	$ 174,162	$ -	$ -

Montowese
Cable/TV Schedule
9/30/2022

10/31/2021	Comcast	$2,994.25
11/30/2021	Comcast	$2,994.25
12/31/2021	Comcast	$3,002.48
1/31/2022	Comcast	$2,994.25
2/28/2022	Comcast	$3,002.48
4/30/2022	Comcast	$3,002.48
4/30/2022	Comcast	$3,002.48
5/31/2022	Comcast	$3,002.48
6/30/2022	Comcast	$3,002.48
7/31/2022	Comcast	$3,002.48
8/31/2022	Comcast	$3,152.91
9/30/2022	Comcast	$3,153.11
		36,306.13

*Total Cable Expense account #6545 is $36,306.13, pg 20
Total Disallowed on pg 29, $32,706

Montowese
Televisions
9/30/2022

Date	Vendor		# Televisions	Location	Amount
11/30/2021	Med Part	Televisions	2	Resident Rooms	$1,281.52
					$1,281.52

Total Cable Expense account #6545 is $36,306
Total Disallowed on pg 29, $32,706

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2022	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
CWPM, LLC	25 Norton Place, Plainville, CT 06062	○	⊙		Rubbish Removal	33,384			22	6f
Procare LTC Pharmacy	111 Excutive Blvd Farmingdale NY 11735	⊙	○	Common Owners: Minority Interest	Pharmacy Services	830,057			20	5A2 &
ADP	PO Box 842875, Boston, MA 02284-2875	○	⊙		Payroll Processing	22,368			16	m13
Executive Landscaping	PO Box 185790, Hamden, CT 06518	○	⊙		Landscaping and Snow Removal Services	46,960			22	6f
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2022	22	37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	153,128	153,128		
b. Heat	$	61,721	61,721		
c. Light & Power	$	143,890	143,890		
d. Water	$	55,836	55,836		
e. Equipment Lease (*Provide detail on page 6*)	$	18,159	18,159		
f. Other (*itemize*)	$	120,313	120,313		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	553,047	553,047		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$				
d. Movable Equipment	$	145,020	145,020		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	145,020	145,020		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$	611,745	611,745		
b. Mortgage Expense	$				
c. Leasehold Improvements	$	9,024	9,024		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	620,769	620,769		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	945,512	945,512		
10. Property Taxes					
a. Real estate taxes paid by owner	$	193,782	193,782		
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	12,554	12,554		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,917,637	1,917,637		

* 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	$ 24,071		
Rubbish Removal	$ 32,246		
Snow Removal	$ 22,889		
Supplies	$ 41,107		
Total Other Repairs and Maintenance	$ 120,313	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2022	23	37

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

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			9	2021	775,792		775,792	520,870	S/L	Various	142,985	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative			9	2022	37,710		37,710		S/L	Various	1,646	
d. Standard Resident			9	2022	3,889		3,889		S/L	Various	389	
e. Specialized Resident												
Total Acquired during this report period					41,599		41,599				2,035	
D-3. Subtotal												145,020
E. ***Total Depreciation***												145,020

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	Pick One Movable Category	Cost	Useful Life	Depreciation	
Additions:						
11/30/2021	Med Part-32" Television for Resident	Standard Resident	$ 1,281	5	$ 128	
11/30/2021	Facility Compliance Fire Pro-Battery Charger	Administrative	$ 2,286	5	$ 229	
1/31/2022	Home Depot Pro- Smoke Detector	Administrative	$ 1,547	10	$ 77	
8/31/2022	Daniels Equipment-2 Dryers	Administrative	$ 12,677	10	$ 634	
9/30/2022	Creative Office Interiors-Chairs	Administrative	$ 21,200	15	$ 707	
Various	See Attached	Standard Resident	$ 2,608	5	$ 261	
Total additions for Movable Equipment			$ 41,599		$ 2,035	*
Deletions:						
Total deletions for Movable Equipment			$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Various	See Attached	$ 47,065	Various	$ 2,887	
Total additions for Leasehold Improvement		$ 47,065		$ 2,887	*
Deletions:					
Various	See Attached	$ (313,311)		$ (6,137)	
Total deletions for Leasehold Improvement		$ (313,311)		$ (6,137)	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2022	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. Organization Expense	Jan	2018	10 years	6,059,160	2,151,191	S/L		611,745	
2.									
3.									
A-4. Subtotal									611,745
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	9	2021	Various	313,311	48,813	S/L	Variou	6,137	
2. Disposals (attach schedule)	12	2021	Various	(313,311)	(48,813)			(6,137)	
3. Acquired during this report period (attach schedule)	9	2022		47,065		S/L	Variou	2,887	
C-4. Subtotal									2,887
D. ***Total Amortization***									614,632

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation C	2442	9/30/2022	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 _____				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)	Sale Leaseback			
h. Date of Refinancing	12/28/21			
i. New Interest Rate	Lease			
j. Term of Mortgage (number of years)	5			
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off	12,110,250			

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health & Rehabilitation C	2442	9/30/2022	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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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 & Rehabilitatio	2442	9/30/2022	27 | 37

Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (*Specify*)		$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		$				
12. D. Other Interest Expense (*Specify*)		$	25,746	25,746		
Vendor Interest=$25,746						
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)		$	25,746	25,746		
14. Insurance						
a. Insurance on Property (buildings only)		$	138,344	138,344		
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)***		$	138,344	138,344		
15. ***Total All Expenditures (A-13 thru C-14)***		$	20,151,947	20,151,947		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health & Rehabilitation Center	2442	9/30/2022	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 $	1,035,547	1,035,547		
4.			Other - See attached Schedule $	3,947	3,947		
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $	161	161		
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $	60,701	60,701		
10.			Accounting $	56,367	56,367		
10a.			Legal $				
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $	11,967	11,967		
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 * $	3,400	3,400		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $	(193,644)	(193,644)		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	35,254	35,254		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $	1,747	1,747		
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	1,015,447	1,015,447		

* 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 Salaries & Benefits	$ 3,947		
Total Other Salaries Adjustment			$ 3,947	$ -	$ -

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	$ 16,029		
16	M13	Other Professional Fees	$ 19,225		
Total Other A&G Adjustments			$ 35,254	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2022	29	37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	1,015,447	1,015,447		
Page 20 - Resident Care Supplies***								
27.			Prescription Drugs	$	855,921	855,921		
28.			Ambulance/Limousine	$	24,243	24,243		
29.			X-rays, etc	$	35,028	35,028		
30.			Laboratory	$	57,994	57,994		
31.			Medical Supplies	$	15,086	15,086		
32.			Oxygen (non emergency)	$	33,977	33,977		
33.			Occupational Therapy	$	2,077	2,077		
34.			Other - See Attached Schedule	$	83,065	83,065		
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$	65,684	65,684		
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.	$	1,529	1,529		
44.			Other - Miscellaneous Administrative	$				
45.			Management Fees Direct	$	(52,812)	(52,812)		
46.			Management Fees Indirect	$	(46,944)	(46,944)		
47.			Other - Direct	$				
Not For Profit Providers Only								
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	$				
49.	***Total Amount of Decrease (Items 1 - 48)***			$	2,090,295	2,090,295		

*** 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	$ 50,359		
20	5j	Radio + Television Revenue	$ 32,706		
Total Other Ancillary Costs			$ 83,065	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excluded Movable Equipment (See Attached)	$ 65,684		
Total Excess Movable Equipment Depreciation			$ 65,684	$ -	$ -

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)
Total Other Adjustments			$ -	$ -	$ -

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Cent	2442	9/30/2022	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	11,326,803	11,326,803		
b. Medicaid Room and Board Contractual Allowance **	$	(5,132,760)	(5,132,760)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	4,449,072	4,449,072		
b. Medicare Room and Board Contractual Allowance **	$	1,161,601	1,161,601		
4. a. Private-Pay Residents and Other	$	4,322,984	4,322,984		
b. Private-Pay Room and Board Contractual Allowance **	$	(278,236)	(278,236)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	447,723	447,723		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(447,723)	(447,723)		
c. Prescription Drugs - Non-Medicare	$	448,709	448,709		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(448,709)	(448,709)		
2. a. Medical Supplies - Medicare	$	3,086	3,086		
b. Medical Supplies - Medicare Contractual Allowance **	$	(1,358)	(1,358)		
c. Medical Supplies - Non-Medicare	$	453	453		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(453)	(453)		
3. a. Physical Therapy - Medicare	$	1,926,225	1,926,225		
b. Physical Therapy - Medicare Contractual Allowance **	$	(1,394,924)	(1,394,924)		
c. Physical Therapy - Non-Medicare	$	1,046,100	1,046,100		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(1,046,100)	(1,046,100)		
4. a. Speech Therapy - Medicare	$	474,385	474,385		
b. Speech Therapy - Medicare Contractual Allowance **	$	(327,142)	(327,142)		
c. Speech Therapy - Non-Medicare	$	224,325	224,325		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(224,325)	(224,325)		
5. a. Occupational Therapy - Medicare	$	1,919,331	1,919,331		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(1,450,407)	(1,450,407)		
c. Occupational Therapy - Non-Medicare	$	1,070,775	1,070,775		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(1,070,775)	(1,070,775)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	630,706	630,706		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	17,629,366	17,629,366		
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)*	$	1,529	1,529		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$				
V. Total Other Revenue (1 thru 8)	$	1,529	1,529		
VI. Total All Revenue (III +V)	$	17,630,895	17,630,895		

* *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)
	Retroactives	$ 70,397		
	Retroactives	$ (13,941)		
	Misc Revenue from CRF funding	$ 574,250		
Total Other Resident Revenue		$ 630,706	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
pg 31, L A2	Interest on A/R		$ 1,529		
Total Interest Income			$ 1,529	$ -	$ -

Schedule of Other Revenue

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

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Ce	2442	9/30/2022	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 183,606
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 2,014,864
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 25,769
5. Prepaid Expenses				$ 383,334
a. Prepaid Insurance		147,650		
b. Prepaid Health Insurance		24,300		
c. Prepaid Tax		154,152		
d. See Schedule		57,232		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ (247,000)
Medicaid Advance		(247,000)		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,360,573
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	47,065		$ 44,178
	Accum. Depreciation	2,887	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	456,552		$ (209,339)
	Accum. Depreciation	665,891	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 360,839
Moveable Equipment Carryforward		360,839		
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 195,678

* 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	
		Prepaid Expenses	$ 57,232
Total Prepaid Expenses			$ 57,232

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

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

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

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

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

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Ce	2442	9/30/2022	32	37

Account				Amount
		Total Brought Forward:	$	2,556,251
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			$	
2. Land Improvements	*Historical Cost			
	Accum. Depreciation	Net	$	
3. Buildings	*Historical Cost			
	Accum. Depreciation	Net	$	
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation	Net	$	
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation	Net	$	
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation	Net	$	
7. Minor Equipment-Not Depreciable			$	
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)			$	
D. Investment and Other Assets				
1. Deferred Deposits			$	
2. Escrow Deposits			$	
3. Organization Expense	*Historical Cost	6,059,160		
	Accum. Depreciation	2,762,936 Net	$	3,296,224
4. Goodwill (Purchased Only)			$	(16,927)
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*)			$	392,854
Start Up Costs		165,543		
Deposits-Lease & Security Deposit		227,311		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)			$	3,672,151
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$	6,228,402

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2022	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 3,616,824
	2. Notes Payable (*itemize*)				$
	See Schedule				
	3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
	Name of Lender	Purpose	Amount	Date Due	
	4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 579,278
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 502,372
	7. Medicare Final Settlement Payable				$
	8. Medicare Current Financing Payable				$
	9. Mortgage Payable (*Current Portion*)				$
	10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
	11. Accrued Income Taxes*				$
	12. Other Current Liabilities (*itemize*)				$ 1,562,419
	Acc'd Operating Expenses	266,630			
	Acc'd Expense - Sales Tax	957			
	Provider Taxes Due	1,294,832	See Schedule		
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 6,260,893

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2022	34	37

Account				Amount
			Total Brought Forward:	6,260,893
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				$
3. Loans from Owners or Related Parties (*itemize*)				$ 7,915,778
Name and Address of Lender	Amount	Loan Date		
Intercompany	7,206,319			
Notes Pay-Procare Investement	709,459			
4. Other Long-Term Liabilities (*itemize*)				$ 376,614
Notes Payable-Procare CT	376,614			
See Schedule				
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ 8,292,392
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 14,553,285

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation C	2442	9/30/2022	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	$ (9,178,829)
	6. Gain or Loss for Period 10/1/2021 thru 9/30/2022	$ (2,521,054)
	7. Total Net Worth	$ (8,324,883)
C.	***Total Reserves and Net Worth***	$ (8,324,883)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 6,228,402

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Cen	2442	9/30/2022	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2021			$ (5,148,532)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 17,630,892
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 20,151,946
D.	Net Income or Deficit			$ (2,521,054)
E.	Balance			$ (7,669,586)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
			(656,719)	
	Fixed Asset Contribtuion		1,422	
	2. Other (*itemize*)			
F-3.	Total Additions			$ (655,297)
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***	09/30/22		$ (8,324,883)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation	2442	9/30/2022	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

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
Michael Mosier	(860) 751-3900

Contact Email Address
mmosier@athenahealthcare.com