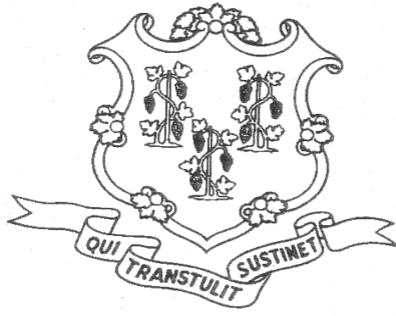


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2023

Name of Facility (as licensed) New Milford Rehabilitation, LLC	
Address (No. & Street, City, State, Zip Code) 30 Park Lane East, New Milford, CT 06776	
Type of Facility Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

License Numbers:	CCNH / RHNS 2207C	(Specify)	(Specify)	Medicare Provider 07-5416
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Medicaid Provider Numbers:	000009266	CCNH / RHNS	(Specify)	(Specify)
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### General Information

Name of Facility (as licensed) New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2023	Page 1	of 37
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#### Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for New Milford Rehabilitation, LLC [facility name], for the cost report period beginning October 1, 2022 and ending September 30, 2023, 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) James Noonan			Printed Name (Owner) Moshe Bernstein		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility New Milford Rehabilitation, LLC	Period Covered:	From 10/1/2022	To 9/30/2023	
Address of Facility 30 Park Lane East, New Milford, CT 06776				
Report Prepared By Zella Healthcare Consulting, LLC	Phone Number 203-808-8197	Date 1/13/2024		
Item	Total	CCNH / RHNS	(Specify)	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (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.**

**General Information and Questionnaire**  
**Type of Facility - Organization Structure**

Phone No. of Facility 860-355-0971		Report for Year Ended 9/30/2023	Page 2	of 37
Name of Facility (as shown on license) New Milford Rehabilitation, LLC		Address (No. & Street, City, State, Zip) 30 Park Lane East, New Milford, CT 06776		
License Numbers:	CCNH / RHNS 2207C	(Specify)	(Specify)	Medicare Provider No. 07-5416
Type of Facility (Check appropriate box(es)) Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box) <input type="checkbox"/> Proprietorship <input checked="" type="radio"/> LLC <input type="checkbox"/> Partnership <input type="checkbox"/> Profit Corp. <input type="checkbox"/> Non-Profit Corp. <input type="checkbox"/> Government <input type="checkbox"/> 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? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
<b>Administrator</b>				
Name of Administrator James Noonan		Nursing Home Administrator's License No.:	2040	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

**General Information and Questionnaire  
 Partners/Members**

Name of Facility New Milford Rehabilitation, LLC		License No. 2207C	Report for Year Ended 9/30/2023	Page 3	of 37
Legal Name of Partnership/LLC New Milford Rehabilitation, LLC		Business Address 30 Park Lane East, New Milford, CT 06776		State(s) and/or Town(s) in Which Registered Connecticut	
Name of Partners/Members	Business Address	Title		% Owned	
YMW CT, LLC	1165 King Street, Greenwich, CT 06831	Owner		7.06%	
SJJ, LLC	1165 King Street, Greenwich, CT 06831	Owner		7.06%	
GW Holdings, LLC	1165 King Street, Greenwich, CT 06831	Owner		54.11%	
IK Greenwich, LLC	1165 King Street, Greenwich, CT 06831	Owner		7.06%	
WCTHC, LLC	1165 King Street, Greenwich, CT 06831	Owner		24.71%	

## General Information and Questionnaire Corporate Owners

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2023	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address		State(s) in Which Incorporated	
N/A				
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
N/A				
Names of Stockholders Owning at Least 10% of Shares				
N/A				

### General Information and Questionnaire Individual Proprietorship

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2023	Page 3B	of 37
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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



**General Information and Questionnaire  
 Related Parties\***

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2023	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?     Yes     No    If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Moshe Bernstein	1165 King Street, Greenwich, CT 06831	<input type="radio"/>	<input checked="" type="radio"/>		Management Services	Page 16 Line m12	65,000	65,000
Mordi Blass	1165 King Street, Greenwich, CT 06831	<input type="radio"/>	<input checked="" type="radio"/>		Management Services	Page 16 Line m12	65,000	65,000
Sparkle	1165 King Street, Greenwich, CT 06831	<input checked="" type="radio"/>	<input type="radio"/>	1%	Housekeeping Services	Page 20 Line 4b	371,467	395,798
Sparkle	1165 King Street, Greenwich, CT 06831	<input checked="" type="radio"/>	<input type="radio"/>	1%	Laundry Services & Equipment	Page 19 Line 3b & 3d	101,388	108,047
Farmington Rehab Center, LLC	416 Colt Highway, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Administrative Oversight	Page 16 Line m13	101,453	101,453
NMHC Realty, LLC	1165 King Street, Greenwich, CT 06831	<input type="radio"/>	<input checked="" type="radio"/>		Rental Expense	Page 22 Line 9	1,629,400	964,690
NMHC Realty, LLC	1165 King Street, Greenwich, CT 06831	<input type="radio"/>	<input checked="" type="radio"/>		Property Insurance	Page 27 Line 14a	41,033	41,033
NMHC Realty, LLC	1165 King Street, Greenwich, CT 06831	<input type="radio"/>	<input checked="" type="radio"/>		Real Estate Taxes	Page 22 Line 10b	129,567	129,567
Skilled Marketing Solutions	1165 King Street, Greenwich, CT 06831	<input checked="" type="radio"/>	<input type="radio"/>	4%	Website Service	Page 16 Line m3	1,188	1,261

\* Use additional sheets if necessary.

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

## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2023	Page 5	of 37
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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 ( <i>See listing page 13</i> )
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.

**General Information and Questionnaire**  
**Other Lines of Business**

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2023	Page 6	of 37
Square footage of entire facility.		53,395		
<b>Outpatient Therapy</b>				
Does the Facility provide outpatient therapy services?		No		
<i>If yes, please complete the following:</i>				
Square footage of therapy space.				
<b>Meals on Wheels</b>				
Does the facility provide Meals on Wheels?		No		
<i>If yes, please complete the following:</i>				
Square footage of kitchen				
Number of meals served per week				
No	Are meals included in meals served on page 18 of the Annual Report?			
No	Are direct costs included in the Annual Report?			
<i>If yes, please state where costs are reported.</i>				
No	Are drivers for the program included in the facility's payroll?			
<i>If yes, please complete the following:</i>				
Amount Reported				
Annual Report page and line				
Please state the salary amounts of specific cooks and/or dietary aides				
Please state where the cooks and/or dietary aides are reported in the Annual Report				
<b>Apartments, Independent Living, Assisted Living</b>				
Does the facility have apartments, independent living, and/or assisted living?		No		
<i>If yes, please complete the following:</i>				
Square footage of apartments				
Square footage of independent living				
Square footage of assisted living				
Please identify the services provided:				

**General Information and Questionnaire  
 Other Lines of Business (Continued)**

Name of Facility New Milford Rehabil	License No. 2207C	Report for Year Ended 9/30/2023	Page 7	of 37
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**Child Day Care**

Does the Facility provide Child Day Care?  No

*If yes, please complete the following:*

	Square footage of child day care space.
	Average number of daily participants.
	Number of meals per day provided to child day care.
	Nature of services provided:

**Adult Day Care**

Does the Facility provide Adult Day Care?  No

*If yes, please complete the following:*

	Square footage of adult day care space.
	Please state where it is located in relation to the facility.
	Average number of daily participants.
	Number of meals per day provided to adult day care.
	Nature of services provided:

### Schedule of Resident Statistics

Name of Facility			License No.		Report for Year Ended				Page	of			
New Milford Rehabilitation, LLC			2207C		9/30/2023				8	37			
	Total All Levels	Total CCNH / RHNS Level	Total	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH / RHNS	(Specify)	(Specify)	Total	CCNH / RHNS	(Specify)	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	148	148			148	148							
B. On last day of THIS report period	148	148							148	148			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	118	118			118	118							
B. As of midnight of THIS report period	115	115							115	115			
3. Total Number of Days Care Provided During Period													
A. Medicare	8,022	8,022			6,407	6,407			1,615	1,615			
B. Medicaid (Conn.)	25,806	25,806			19,255	19,255			6,551	6,551			
C. Medicaid (other states)													
D. Private Pay	5,112	5,112			3,771	3,771			1,341	1,341			
E. State SSI for RCH													
F. Other (Specify) Managed Care, VA	5,075	5,075			3,853	3,853			1,222	1,222			
G. Total Care Days During Period (3A thru F)	44,015	44,015			33,286	33,286			10,729	10,729			
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	90	90			66	66			24	24			
5. <b>Total Resident Days (3G + 4A + 4B)</b>	44,105	44,105			33,352	33,352			10,753	10,753			

**Annual Report of Long-Term Care Facility**

**Schedule of Resident Statistics (Cont'd)**

Name of Facility New Milford Rehabilitation, LLC			License No. 2207C			Report for Year Ended 9/30/2023			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> 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)	(Specify)	Lost			Gained			CCNH / RHNS	(Specify)	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
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)	(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 / RHNS	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	(Specify)	R.C.H.	ICF-MR					
No. of Residents	15	69		31									
Per Diem Rate													
a. One bed rm.	N/A	N/A		N/A									
b. Two bed rms.	Various	#####		495.00									
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments				TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)					
A. Medicare - Part B				1,278	1,278								
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other				6,373	6,373								
<b>D. Total Physical Therapy Treatments</b>				<b>7,651</b>	<b>7,651</b>								
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B				357	357								
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other				1,105	1,105								
<b>D. Total Speech Therapy Treatments</b>				<b>1,462</b>	<b>1,462</b>								
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B				1,081	1,081								
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other				6,182	6,182								
<b>D. Total Occupational Therapy Treatments</b>				<b>7,263</b>	<b>7,263</b>								

**Annual Report of Long-Term Care Facility**

CSP-10 Rev. 3/2023

**Report of Expenditures - Salaries & Wages**

Name of Facility	License No.	Report for Year Ended	Page	of					
New Milford Rehabilitation, LLC	2207C	9/30/2023	10	37					
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No									
	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
<b>A. Salaries and Wages*</b>									
1. Operators/Owners (Complete also Sec. I of Schedule A1)									
2. Administrator(s) (Complete also Sec. III of Schedule A1)	160,560		2,080						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	268,630		9,162						
5. Dietary Service									
a. Head Dietitian									
b. Food Service Supervisor	72,047		2,150						
c. Dietary Workers	532,369		26,016						
6. Housekeeping Service									
a. Head Housekeeper									
b. Other Housekeeping Workers									
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance	63,558		2,080						
b. Other Maintenance Workers	75,272		3,582						
8. Laundry Service									
a. Supervisor									
b. Other Laundry Workers									
9. Barber and Beautician Services									
10. Protective Services									
11. Accounting Services									
a. Head Accountant									
b. Other Accountants									
12. Professional Care of Residents									
a. Directors and Assistant Director of Nurses	300,702		4,574						
b. RN									
1. Direct Care	1,734,360		34,644						
2. Administrative**	500,492		7,288						
c. LPN									
1. Direct Care	1,552,252		44,082						
2. Administrative**	49,134		1,883						
d. Aides and Attendants	2,137,630		93,718						
e. Physical Therapists	16,123		424						
f. Speech Therapists									
g. Occupational Therapists									
h. Recreation Workers	205,215		9,954						
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	353,962	(3,929)	9,389						
n. Marketing									
o. Other (Specify) See Attached Schedule									
<i>A-13. Total Salary Expenditures</i>	8,022,306	(3,929)	251,026						

\* 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 in the Adjustment column.





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

Name of Facility				License No.		Report for Year Ended			Page	of
New Milford Rehabilitation, LLC				2207C		9/30/2023			11	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	(Specify)	(Specify)							
<b>Section I - Operators/Owners</b>										
<b>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).</b>										

\* 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.

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

Name of Facility (as licensed)				License No.	Report for Year Ended				Page	of
New Milford Rehabilitation, LLC				2207C	9/30/2023				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)	(Specify)							
<b>Section III - Administrators***</b>										
James Noonan	160,560			Non Discriminatory	Administrator	2,080	A2	N/A		
<b>Section IV - Assistant Administrators</b>										

\*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.

**B. Report of Expenditures - Professional Fees**

Name of Facility	License No.	Report for Year Ended	Page	of					
New Milford Rehabilitation, LLC	2207C	9/30/2023	13	37					
Total Cost and Hours									
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>									
1. Dietitian									
2. Dentist	7,800	(7,800)	N/A						
3. Pharmacist	23,369	(23,369)	N/A						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	387,830		4,315						
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	64,500		249						
b. Utilization Review (Title 18 and 19 only) monthly meeting									
c. Resident Care**									
d. Administrative Services facility									
1. Infection Control Committee (Quarterly meetings)									
2. Pharmaceutical Committee (Quarterly meetings)									
3. Staff Development Committee (Once annually)									
e. Other (Specify)									
Other Physianni	5,005	(5,005)	N/A						
9. Speech Therapist									
a. Resident Care	85,647		914						
b. Other									
10. Occupational Therapist									
a. Resident Care	361,243	(361,243)	4,186						
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	16,373		254						
2. Administrative***									
b. LPN									
1. Direct Care	324,266		5,372						
2. Administrative***									
c. Aides	664,099		14,641						
d. Other									
12. Other (Specify)									
See Attached Schedule	85,072		860						
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>2,025,204</b>	<b>(397,417)</b>	<b>30,791</b>						

\* 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 in the Adjustment column.

\*\*\* 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.

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

Name of Facility New Milford Rehabilitation, LLC		License No. 2207C		Report for Year Ended 9/30/2023		Page 14		of 37	
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship					
		Yes	No						
Connecticut Dental Partners, 300 Church Street, Wallingford, CT	Dentist	<input type="radio"/>	<input checked="" type="radio"/>						
Guardian Consulting Services	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>						
Preferred Therapy, 850 Silas Dean Highway, Wethersfield, CT	PT, OT, ST	<input type="radio"/>	<input checked="" type="radio"/>						
Dr. Kenneth Marici, 2 Old Park Lane, New Milford, CT 06776	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>						
Dr. John Mullen, 131 Kent Road, Rt 7, New Milford, CT 06776	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>						
Patricia Jones	Clinical Consultant	<input type="radio"/>	<input checked="" type="radio"/>						
Clipboard Health	Nursing Agency	<input type="radio"/>	<input checked="" type="radio"/>						
Staffontap	Nursing Agency	<input type="radio"/>	<input checked="" type="radio"/>						
Karen Bialog	Clinical Consultant	<input type="radio"/>	<input checked="" type="radio"/>						
		<input type="radio"/>	<input checked="" type="radio"/>						
		<input type="radio"/>	<input checked="" type="radio"/>						
		<input type="radio"/>	<input checked="" type="radio"/>						
		<input type="radio"/>	<input checked="" type="radio"/>						
		<input type="radio"/>	<input checked="" type="radio"/>						
		<input type="radio"/>	<input checked="" type="radio"/>						
		<input type="radio"/>	<input checked="" type="radio"/>						
		<input type="radio"/>	<input checked="" type="radio"/>						
		<input type="radio"/>	<input checked="" type="radio"/>						
		<input type="radio"/>	<input checked="" type="radio"/>						
		<input type="radio"/>	<input checked="" type="radio"/>						
		<input type="radio"/>	<input checked="" type="radio"/>						

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

**C. Expenditures Other Than Salaries - Administrative and General**

Name of Facility	License No.	Report for Year Ended					Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2023					15	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	\$ 244,783	244,903	(120)					
2. Disability Insurance	\$							
3. Unemployment Insurance	\$ 56,981	57,009	(28)					
4. Social Security (F.I.C.A.)	\$ 603,699	603,995	(296)					
5. Health Insurance	\$ 1,125,357	1,125,357						
6. Life Insurance (employees only) (not-owners and not-operators)	\$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 66,285	66,285						
8. Uniform Allowance	\$							
9. Other (Specify) See Attached Schedule	\$	36,957	(36,957)					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$							
c. Bad Debts*	\$							
d. Accounting and Auditing	\$ 35,173	35,173						
e. Legal (Services should be fully described on Page 15b)	\$ 1,279	7,202	(5,923)					
f. Insurance on Lives of Owners and Operators (Specify)*	\$							
g. Office Supplies	\$ 51,284	51,284						
h. Telephone and Cellular Phones								
1. Telephone & Pagers	\$ 29,813	29,813						
2. Cellular Phones	\$ 2,800	4,448	(1,648)					
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	\$ 2,144	(377,193)	379,337					
3. Resident Day User Fee	\$ 732,274	732,274						
<b>Subtotal</b>	\$ 2,951,873	2,617,507	334,365					

\* Facility should self-disallow the expense in the Adjustment column.

(Carry Subtotals forward to next page)

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

**Schedule of Other Employee Benefit:**

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Employee Relations	\$ 36,957	\$ (36,957)				
<b>Total</b>	\$ 36,957	\$ (36,957)	\$ -	\$ -	\$ -	\$ -

**Schedule of Other Taxes**

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
State Tax	\$ (379,337)	\$ 379,337				
State Sales & Use Tax	\$ 2,144					
<b>Total</b>	\$ (377,193)	\$ 379,337	\$ -	\$ -	\$ -	\$ -

**General Information and Questionnaire**  
**Accounting Basis**

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2023	Page 15b	of 37
The records of this facility for the period covered by this report were maintained on the following basis:				
<input checked="" type="radio"/> Accrual <input type="radio"/> Cash <input type="radio"/> Modified Cash				
Is the accounting basis for this period the same as for the previous period? <input checked="" type="radio"/> Yes <input type="radio"/> No                    If "No," explain.				
<b>Independent Accounting Firm</b>				
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)		
1 SY Consultant		1138 E. 12th Street, Brooklyn, NY 11230		
2 Pease & Associates		1111 Superior Avenue, Cleveland, OH 44114		
3 Bonadio & Co. LLP		1040 Avenue of the Americas, 3rd Floor, New York, NY 10018		
4 Zella Healthcare Consulting / Clifton Larson Allen		7 Eastview Drive, Simsbury, CT 06070 / PO Box 829709, Philadelphia, PA		
Services Provided by This Firm ( <i>describe fully</i> )				
1	Consulting		\$	18,000
2	Accounting & HHS		\$	6,000
3	401K		\$	4,150
4	Medicare & Medicaid Cost Report Preparation (6,500 / 523)		\$	7,023
			Charge for Services Provided	
			\$	35,173
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="radio"/> Yes <input type="radio"/> No    Page 15 Line 1d				
<b>Legal Services Information</b>				
Name of Legal Firm or Independent Attorney			Telephone Number	
1 Goldman, Gruder and Woods			203-899-8900	
2 Robinson & Cole			860-275-8200	
3 US Treasury			N/A	
4				
5				
Address ( <i>No. &amp; Street, City, State, Zip Code</i> )				
1 200 Connecticut Ave., Norwalk, CT 06854				
2 280 Trumbull St., Hartford, CT 06103				
3 N/A				
4				
5				
Services Provided by This Firm ( <i>describe fully</i> )				
1	Collections (Disallowed)		\$	5,696
2	General Legal Counsel		\$	1,279
3	Legal (Disallowed)		\$	227
4			\$	
5			\$	
			Charge for Services Provided	
			\$	7,202
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="radio"/> Yes <input type="radio"/> No    Page 15 Line 1e				

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

Name of Facility	License No.	Report for Year Ended					Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2023					16	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
<b>Subtotals Brought Forward:</b>		2,951,873	2,617,507	334,365				
<b>i. Travel and Entertainment</b>								
1. Resident Travel and Entertainment	\$							
2. Holiday Parties for Staff	\$							
3. Gifts to Staff and Residents	\$							
4. Employee Travel	\$ 29,354	29,354						
5. Education Expenses Related to Seminars and Conventions	\$ 7,474	19,098	(11,624)					
6. Automobile Expense <i>not purchase or depreciation</i> )	\$	49,000	(49,000)					
7. Other (Specify) See Attached Schedule	\$							
<b>m. Other Administrative and General Expenses</b>								
1. Advertising Help Wanted <i>all such expenses</i> )	\$ 91,074	91,074						
2. Advertising Telephone Directory <i>all such expenses</i> )***	\$	5	(5)					
3. Advertising Other (Specify)*** See Attached Schedule	\$	48,563	(48,563)					
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)***	\$ 880	880						
7. Postage	\$ 5,097	5,097						
* 8. Dues and Membership Fees to Professional Associations (Specify) See Attached Schedule	\$	8,964	(8,964)					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	330	(330)					
9. Subscriptions	\$ 8,820	8,820						
10. Contributions*** See Attached Schedule	\$	2,025	(2,025)					
11. Services Provided by Contract (Specify and Complete Schedule C-2, Page 21 for each firm or individual)	\$ 34,551	34,551						
12. Administrative Management Services**	\$	130,000	(130,000)					
13. Other (Specify) See Attached Schedule	\$ 223,020	302,615	(79,595)					
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 3,352,142	3,347,883	4,259					

\* 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 in the Adjustment column.



## Schedule of Other Travel and Entertainment

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

## Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Promotional Advertising	\$ 48,563	\$ (48,563)				
<b>Total Other Advertising</b>	\$ 48,563	\$ (48,563)	\$ -	\$ -	\$ -	\$ -

## Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Various (Disallowed)	\$ 8,964	\$ (8,964)				
<b>Total Dues</b>	\$ 8,964	\$ (8,964)	\$ -	\$ -	\$ -	\$ -

## Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Contributions	\$ 2,025	\$ (2,025)				
<b>Total Contributions</b>	\$ 2,025	\$ (2,025)	\$ -	\$ -	\$ -	\$ -

## Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Employee Background Checks	\$ 10,954					
Administrative Oversight	\$ 101,453					
Unemployment Tax Management	\$ 1,755	\$ (1,755)				
Data Processing Fees	\$ 30,671					
Software Maintenance	\$ 62,395					
Facility Licenses	\$ 7,144					
Employee Licenses	\$ 472					
Bank Charges - Routine	\$ 9,931					
Bank Charges - Unallowable	\$ 2,840	\$ (2,840)				
Prior Period Expenses	\$ 75,000	\$ (75,000)				
<b>Total Other Administrative and General</b>	\$ 302,615	\$ (79,595)	\$ -	\$ -	\$ -	\$ -

**Schedule C-1 - Management Services\***

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2023	Page of 17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Moshe Bernstein	65,000	Management Services	Page 16 Line m12
Mordi Blass	65,000	Management Services	Page 16 Line m12

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

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

Name of Facility	License No.	Report for Year Ended				Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2023				18	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
2. Dietary							
a. In-House Preparation & Service							
1. Raw Food	\$ 342,592	342,592					
2. Non-Food Supplies	\$ 31,198	31,198					
3. Other (Specify) _____ Dietary Cleaning Supplies	\$ 12,491	12,491					
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$						
c. Other (Specify) _____ Nutritional Supplements Employee Meals (Disallowed)	\$ 29,876	30,416	(540)				
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	\$ 416,157	416,697	(540)				
2E. Dietary Questionnaire	Total	CCNH / RHNS		(Specify)	(Specify)		
F. Resident Meals: Total no. of meals served per day:*							
G. Is cost of employee meals included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No					
H. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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?	<input type="radio"/> Yes	<input checked="" type="radio"/> No			If yes, specify cost.		
K. Is any revenue collected from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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?	<input type="radio"/> Yes	<input checked="" type="radio"/> No			If yes, specify cost.		
N. Is any revenue collected from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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.

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

Name of Facility		License No.	Report for Year Ended				Page	of
New Milford Rehabilitation, LLC		2207C	9/30/2023				19	37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
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. \$	2,630	2,630				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***		Lbs.						
		Amt. \$						
3. Personal clothing of residents washed, ironed, and/or processed.***		Lbs.						
		Amt. \$						
4. Repair and/or purchase of linens.***		Lbs.						
		Amt. \$						
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	225,407	225,407				
c. Other (Specify) Cleaning Supplies		\$	645	645				
3D. <b>Total Laundry Expenditures</b> (3a + b + c)		\$	228,682	228,682				
3E. Laundry Questionnaire								
F. Is cost of employee laundry included in 3D?		<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.				
G. Did you receive revenue from employees?		<input type="radio"/> Yes <input checked="" type="radio"/> 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?		<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.				
J. Did you receive revenue from these people?		<input type="radio"/> Yes <input checked="" type="radio"/> 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.

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

Name of Facility		License No.	Report for Year Ended				Page	of
New Milford Rehabilitation, LLC		2207C	9/30/2023				20	37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4.	Housekeeping	Sq. Ft. Serviced by Personnel						
a.	In-House Care	Amt. \$						
1.	Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	\$						
b.	Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )	Sq. Ft. Serviced by Personnel						
		Amt. \$	371,467	371,467				
C.	Other ( <i>Specify</i> ) Housekeeping Paper/Plastic	\$	57,143	57,143				
4D.	<b>Total Housekeeping Expenditures</b> (4a + b + c)	\$	428,610	428,610				
5.	Resident Care (Supplies)**							
a.	Prescription Drugs***							
1.	Own Pharmacy	\$						
2.	Purchased from Pharmscript of CT	\$	398,552	(398,552)				
b.	Medicine Cabinet Drugs	\$						
c.	Medical and Therapeutic Supplies	\$	158,616	158,616				
d.	Ambulance/Limousine***	\$	47,281	(47,281)				
e.	Oxygen							
1.	For Emergency Use	\$						
2.	Other***	\$	12,034	(12,034)				
f.	X-rays and Related Radiological Procedures***	\$	23,423	(23,423)				
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$						
h.	Laboratory***	\$	53,731	(53,731)				
i.	Recreation	\$	15,277	15,277				
j.	Direct Management Services*	\$						
k.	Indirect Management Services*	\$						
l.	Cable TV	\$	7,200	22,588	(15,388)			
m.	Other (Specify)**** See Attached Schedule	\$	10,340	33,050	(22,710)			
n.	Physical Therapy Expense	\$	37,790	37,790				
o.	Speech Therapy Expense	\$						
5P.	<b>Total Resident Care Expenditures</b> (5a - 5o)	\$	229,223	802,342	(573,119)			

\* 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 in the Adjustment column.

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



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

Name of Facility New Milford Rehabilitation, LLC			License No. 2207C		Report for Year Ended 9/30/2023				Page of 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)	(Specify)	Pg	Line
All American Waste	PO Box 630, E. Windsor, CT 06088	<input type="radio"/>	<input checked="" type="radio"/>		Trash Removal	39,299			22	6f
Asantino Consulting	42 Robin Hill Lane, Hamden, CT 06518	<input type="radio"/>	<input checked="" type="radio"/>		IT Consultant	29,675			16	m11
MatrixCare	Bin #32, PO Box 1414, Minneapolis, MN 55480	<input type="radio"/>	<input checked="" type="radio"/>		Software	49,339			16	m13
Shamrock Landscaping	Road, Monroe, CT 06468	<input type="radio"/>	<input checked="" type="radio"/>		Landscaping	22,448			22	6f
Sparkle	North, Suire Q, Howell, NJ 06514	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	Housekeeping P/S	371,467			20	4b
Rinaldi Linen	47 Common Court, Waterbury, CT 06704	<input type="radio"/>	<input checked="" type="radio"/>		Laundry	124,019			19	3b
Crown Care Services	1033 N Maple Ave, Toms River, NJ 08755	<input type="radio"/>	<input checked="" type="radio"/>		Shredding	16,141			22	6f
Sparkle	North, Suire Q, Howell, NJ 06514	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	Laundry P/S	101,388			19	3b
Smartlinx Solutions	PO Box 22598 NY, NY 10097	<input type="radio"/>	<input checked="" type="radio"/>		Time Clock	11,844			16	m11
Viventium	768 Bedford Ave, Brooklyn, NY 11205	<input type="radio"/>	<input checked="" type="radio"/>		Payroll	25,015			16	m11
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

\* List all contracted services over \$10,000. Use additional sheets if necessary.

\*\* Refer to Page 4 for definition of related.

\*\*\* Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended					Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2023					22	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	\$ 182,234	182,234						
b. Heat	\$ 139,238	139,238						
c. Light & Power	\$ 172,049	172,049						
d. Water	\$ 65,352	65,352						
e. Equipment Lease ( <i>Provide detail on page 22b</i> )	\$ 8,887	8,887						
f. Other ( <i>itemize</i> ) See Attached Schedule	\$ 153,241	153,241						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	<b>\$ 721,001</b>	<b>721,001</b>						
7. Depreciation ( <i>complete schedule page 23*</i> )								
a. Land Improvements	\$							
b. Building & Building Improvements	\$ 80,082	80,082						
c. Non-Movable Equipment	\$ 8,401	8,401						
d. Movable Equipment	\$ 27,076	26,026	1,050					
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$ 115,559</b>	<b>114,509</b>	<b>1,050</b>					
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )								
a. Organization Expense	\$							
b. Mortgage Expense	\$							
c. Leasehold Improvements	\$							
d. Other ( <i>Specify</i> )	\$							
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	<b>\$</b>							
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 1,629,400	1,629,400						
10. Property Taxes								
a. Real estate taxes paid by owner	\$							
b. Real estate taxes paid by lessor	\$ 129,567	129,567						
c. Personal property taxes	\$ 34,235	34,235						
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$ 1,908,761</b>	<b>1,907,711</b>	<b>1,050</b>					

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





### General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility			License No.	Report for Year Ended			Page	of
New Milford Rehabilitation, LLC			2207C	9/30/2023			22b	37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease		Amount Claimed
	Yes	No						
TIAA Copier, 245 Park Avenue, New York, NY 10167	<input type="radio"/>	<input checked="" type="radio"/>	Copier	11/09/18	63 Months	8,887		8,887
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
							<b>Total ***</b>	8,887

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

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

### Depreciation Schedule

Name of Facility New Milford Rehabilitation, LLC			License No. 2207C			Report for Year Ended 9/30/2023			Page 23	of 37		
Property Item			Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals		
<b>A. Land Improvements</b>												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal												
<b>B. Building and Building Improvements</b>												
1. Acquired prior to this report period			1,150,759		1,150,759	257,478	SL	Various	77,066			
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)			118,915		118,915		SL	Various	3,016			
B-4. Subtotal										80,082		
<b>C. Non-Movable Equipment</b>												
1. Acquired prior to this report period			51,830		51,830	5,795	SL	Various	3,978			
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)			118,571		118,571		SL	Various	4,423			
C-4. Subtotal										8,401		
		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							
<b>D. Movable Equipment</b>												
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				Var	Var	201,760	201,760	121,563	SL	Various	23,505	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative						13,868	13,868		SL	Various	120	
d. Standard Resident						21,524	21,524		SL	Various	2,401	
e. Specialized Resident												
Total Acquired during this report period						35,392	35,392				2,521	
D-3. Subtotal												26,026
<b>E. Total Depreciation</b>												114,509

Schedule of Land Improvements Acquired during this report period

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

\*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
<b>Additions:</b>				
12/13/2022	Generator Gas Line	\$ 6,475	15	\$ 360
1/9/2023	Hot Water Heat Exchanger	\$ 7,815	15	\$ 391
3/7/2023	Hot Water Heat Exchanger	\$ 9,555	15	\$ 372
6/30/2023	Generator	\$ 75,420	15	\$ 1,676
8/17/2023	Dining Room Remodeling	\$ 19,650	15	\$ 218
<b>Total additions for Building Improvement:</b>		\$ 118,915		\$ 3,016 *
<b>Deletions:</b>				
<b>Total deletions for Building Improvement:</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
5/31/2023	AC	\$ 23,493	10	\$ 979
5/31/2023	Freezer	\$ 74,394	10	\$ 3,100
8/31/2023	Water Softener	\$ 20,684	10	\$ 345
<b>Total additions for Non-Movable Equipment:</b>		\$ 118,571		\$ 4,423 *
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment:</b>		\$ -		\$ - **

\*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	Cost	Useful Life	Depreciation
		Movable Category			
<b>Additions:</b>					
12/3/2022	Electric Lift	Standard Resident	\$ 1,575	5	\$ 263
2/21/2023	Electric Lift	Standard Resident	\$ 1,567	5	\$ 209
3/8/2023	Chairs - Resident Rooms	Standard Resident	\$ 8,229	5	\$ 960
3/21/2023	Chairs - Resident Rooms	Standard Resident	\$ 6,903	5	\$ 805
5/10/2023	2 Electric Beds	Standard Resident	\$ 1,657	5	\$ 138
7/10/2023	Computer Survey Onboarding	Administrative	\$ 10,000	5	\$ 56
9/12/2023	Computers	Administrative	\$ 2,400	5	\$ 40
9/15/2023	Beds	Standard Resident	\$ 1,593	5	\$ 27
9/29/2023	Computer	Administrative	\$ 1,468	5	\$ 24
<b>Total additions for Movable Equipment</b>			\$ 35,392		\$ 2,521 *
<b>Deletions:</b>					
<b>Total deletions for Movable Equipment</b>			\$ -		\$ - **

\*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
<b>Additions:</b>				
<b>Total additions for Leasehold Improvements</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvements</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Annual Report of Long-Term Care Facility**

**Amortization Schedule\***

Name of Facility New Milford Rehabilitation, LLC			License No. 2207C		Report for Year Ended 9/30/2023			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
<b>D. Total Amortization</b>									

\* 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.

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

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2023	Page 25	of 37
<b>11. Property Questionnaire</b>				
<b>Part A</b>				
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> 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 <b>NOT</b> Original Owner, Date of Purchase		04/01/16		
4. Date of Initial Licensure		04/01/16		
5. Total Licensed Bed Capacity		148		
6. Square Footage		53,395		
7. Acquisition Cost				
a. Land				
b. Building				
<b>Part B - Owner and Related Parties</b>		1st Mortgage	2nd Mortgage	3rd Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of 9/30/23				
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>				
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				
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>				
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.**

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

Name of Facility		License No.	Report for Year Ended					Page	of
New Milford Rehabilitation, LLC		2207C	9/30/2023					26	37
Item			Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
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. <b>Total Building Interest Expense</b> (A1 - A4 + B5)			\$						

(Carry Subtotals forward to next page)



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

Name of Facility		License No.	Report for Year Ended				Page	of
New Milford Rehabilitation, LLC		2207C	9/30/2023				27	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
<b>Subtotals Brought Forward:</b>								
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)	\$	2,991	(2,991)					
Other Interest Expense								
13. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)	\$	2,991	(2,991)					
14. Insurance								
a. Insurance on Property (buildings only)	\$	41,033	41,033					
b. Insurance on Automobiles	\$							
c. Insurance other than Property (as specified above)								
1. Umbrella (Blanket Coverage)	\$	27,770	27,770					
2. Fire and Extended Coverage	\$	6,464	6,464					
3. Other (Specify)	\$	123,306	123,306					
Liability Insurance								
14d. <b>Total Insurance Expenditures (14a + b + c)</b>	\$	198,573	198,573					
15. <b>Total All Expenditures (A-13 thru C-14)</b>	\$	17,129,314	18,102,000	(972,686)				

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended		Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2023		30	37
Item	Total	CCNH / RHNS	(Specify)	(Specify)	
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents <i>(CT only)</i>	\$ 12,203,100	12,203,100			
b. Medicaid Room and Board Contractual Allowance **	\$ (5,258,515)	(5,258,515)			
2. a. Medicaid <i>(All other states)</i>	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents <i>(all inclusive)</i>	\$ 3,882,690	3,882,690			
b. Medicare Room and Board Contractual Allowance **	\$ 1,489,988	1,489,988			
4. a. Private-Pay Residents and Other	\$ 5,494,798	5,494,798			
b. Private-Pay Room and Board Contractual Allowance **	\$ (606,680)	(606,680)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 287,606	287,606			
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$ 143,223	143,223			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$				
2. a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$ 513,029	513,029			
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$ 240,552	240,552			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$ 157,495	157,495			
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$ 55,752	55,752			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$ 553,215	553,215			
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$ 215,888	215,888			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other <i>(Specify)</i> - Medicare	\$ (1,413,419)	(1,413,419)			
b. Other <i>(Specify)</i> - Non-Medicare	\$ (525,362)	(525,362)			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 17,433,360	17,433,360			
<b>IV. Other Revenue*</b>					
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 <i>(Specify)</i>	\$ 973	973			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other <i>(Specify)</i>	\$ 98,682	98,682			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 99,655	99,655			
<b>VI. Total All Revenue</b> (III +V)	\$ 17,533,015	17,533,015			

\* 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)	(Specify)
30 II6a	X-Ray	\$ 21,650		
30 II6a	Lab	\$ 42,312		
30 II6a	Contractal Allowance	\$ (1,477,381)		
<b>Total Other Resident Revenue - Medicare</b>		\$ (1,413,419)	\$ -	\$ -

**Schedule of Other Non-Medicare Resident Revenue**

**Related Exp**

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
30 II6b	X-Ray	\$ 4,274		
30 II6b	Lab	\$ 10,713		
30 II6b	Contractal Allowance	\$ (540,349)		
<b>Total Other Resident Revenue</b>		\$ (525,362)	\$ -	\$ -

**Interest Income**

**Account**

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	(Specify)
30 IV5	Interest Income		\$ 973		
<b>Total Interest Income</b>			\$ 973	\$ -	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
30 IV8	Optum	\$ 85,898		
30 IV8	Misc. Income Adjustment	\$ 12,784		
<b>Total Other Revenue</b>		\$ 98,682	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2023	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	333,768
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,063,293
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	110,613
4. Inventories			\$	
5. Prepaid Expenses			\$	285,133
a. Prepaid - Other	4,912			
b. Prepaid Insurance	228,871			
c. Prepaid Sewer & Taxes	51,350			
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	
_____				
_____				
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	2,792,807
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost 1,269,674		\$	932,114
	Accum. Depreciation 337,560	Net		
4. Leasehold Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
5. Non-Movable Equipment	*Historical Cost 170,401		\$	156,205
	Accum. Depreciation 14,196	Net		
6. Movable Equipment	*Historical Cost 237,152		\$	89,563
	Accum. Depreciation 147,589	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	23,241
Construction in Progress	23,241			
See Schedule				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	1,201,123

\* 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	
<b>Total Prepaid Expenses</b>			\$ -

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

Page Ref	Line Ref	Description	
<b>Total Other Current Assets (Itemize)</b>			\$ -

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

Page Ref	Line Ref	Description	
<b>Total Other Other Fixed Assets (Itemize)</b>			\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
<b>Total Other Assets</b>			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
<b>Total Notes Payable</b>			\$ -

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

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			\$ -

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

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			\$ -

### G. Balance Sheet (cont'd)

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2023	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$ 3,993,930	
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements			\$	
	*Historical Cost _____	Net		
	Accum. Depreciation _____			
3. Buildings			\$	
	*Historical Cost _____	Net		
	Accum. Depreciation _____			
4. Non-Movable Equipment			\$	
	*Historical Cost _____	Net		
	Accum. Depreciation _____			
5. Movable Equipment			\$	
	*Historical Cost _____	Net		
	Accum. Depreciation _____			
6. Motor Vehicles			\$	
	*Historical Cost _____	Net		
	Accum. Depreciation _____			
7. Minor Equipment-Not Depreciable			\$	
C-8 <b>Total Leasehold or Like Properties</b> (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense			\$	
	*Historical Cost _____	Net		
	Accum. Depreciation _____			
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care ( <i>itemize</i> )			\$	
_____				
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$ 4,972,812	
Name and Address	Amount	Loan Date		
Various	4,972,812	Various		
7. Other Assets ( <i>itemize</i> )			\$ 37,383	
Deposits		37,380		
Rounding		3		
See Schedule				
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$ 5,010,195	
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$ 9,004,125	

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



### G. Balance Sheet (cont'd)

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2023	Page 34	of 37
Account			Amount	
Total Brought Forward:			2,746,712	
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> )				
\$				
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$ (1)
Rounding				(1)
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ (1)
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 2,746,711



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

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2023	35	37
Account			Amount	
<b>A. Reserves</b>				
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 ( <i>Equity</i> )			\$	
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>B. Net Worth</b>				
1. Owner's Capital			\$	6,826,399
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	
6. Gain or Loss for Period			\$	(568,985)
10/1/2022 thru 9/30/2023				
7. Total Net Worth			\$	6,257,414
<b>C. Total Reserves and Net Worth</b>			\$	6,257,414
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	9,004,125

### H. Changes in Total Net Worth

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2023	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2022			\$	7,074,931
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	17,533,015
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	18,102,000
D. Net Income or Deficit			\$	(568,985)
E. Balance			\$	6,505,946
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
Prior Period Adjustment				(248,532)
F-3. Total Additions			\$	(248,532)
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip )</i>		Title	Amount	
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. <b><i>Balance at End of Period</i></b>		09/30/23	\$	6,257,414

### I. Preparer's/Reviewer's Certification

Name of Facility New Milford Rehabilitation, LLC	License No. 2207C	Report for Year Ended 9/30/2023	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined	<input type="checkbox"/> (Specify)	<input type="checkbox"/> (Specify)		
<b>Preparer/Reviewer Certification</b>				
<p>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.</p>				
Signature of Preparer 	Title Principal	Date Signed 2/14/24		
Printed Name of Preparer Stephen Bernier				
Address Address 7 Eastview Drive, Simsbury, CT 06070		Phone Number 203-808-8197		
Contacted Person Regarding Additional Information Needed Regarding This Report Simon Yisroel		Phone Number 347-254-5765		
Contact Email Address simonyisroel@yahoo.com				