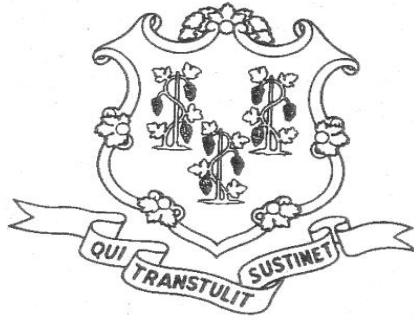


# State of Connecticut



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

Name of Facility (as licensed) Newtown Rehabilitation & Health Care Center	
Address (No. & Street, City, State, Zip Code) 139 Toddy Hill Road, Newtown, CT 06470	
Type of Facility Chronic and Convalescent <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 10207	(Specify)	(Specify)	Medicare Provider 07-5355
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Medicaid Provider Numbers:	CCNH / RHNS 10207	(Specify)	(Specify)
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**General Information**

Name of Facility (as licensed) Newtown Rehabilitation & Health Care Center	License No. 10207	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 Newtown Rehabilitation & Health Care Center [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) Stephanie Vitko-Aniolek			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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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 Newtown Rehabilitation & Health Care Center		Period Covered:	From 10/1/2022	To 9/30/2023
Address of Facility 139 Toddy Hill Road, Newtown, CT 06470				
Report Prepared By Athena Health Care Associates, Inc		Phone Number (860) 751-3900	Date 2/28/2024	
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	Report for Year Ended 9/30/2023	Page 2	of 37
Name of Facility (as shown on license) Newtown Rehabilitation & Health Care Center		Address (No. & Street, City, State, Zip) 139 Toddy Hill Road, Newtown, CT 06470			
License Numbers:	CCNH / RHNS 10207	(Specify)	(Specify)	Medicare Provider No. 07-5355	
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="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> 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 Stephanie Vitko-Aniolek			Nursing Home Administrator's License No.:	1864	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		
Not Applicable					



**General Information and Questionnaire  
 Corporate Owners**

Name of Facility Newtown Rehabilitation & Health Care Cent	License No. 10207	Report for Year Ended 9/30/2023	Page 3A	of 37
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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			
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Names of Stockholders Owning at Least 10% of Shares			
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**General Information and Questionnaire  
 Related Parties\***

Name of Facility Newtown Rehabilitation & Health Care Center	License No. 10207	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	%**				
		<input type="radio"/>	<input checked="" type="radio"/>					
Athena Health care Assoc Inc 401k Plan	135 South Road, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Facility participates in group401k plan	Pg 15 ln 1a7		
Athena Captive LLC	135 South Road, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>		Workers Comp Captive	Pg 15, Ln 1a	140,706	140,706
Misc Facilities	Various	<input checked="" type="radio"/>	<input type="radio"/>	>50%	Interfacility Loans	Pg33, A2		
Athena Health Care Insurance	135 South Road, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	>50%	Self Insured & General Liability Insurance	Pg 15, Ln 1a5	991,711	991,711
Procare LTC	111 Executive Blvd, Farmingdale, NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	<5%	Pharmacy	Pg 20 5a2	231,146	231,146
Athena Health Care Assoc Inc.	135 South Road, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	>50%	See attached			
Procare LTC	111 Executive Blvd, Farmingdale, NY 11735	<input type="radio"/>	<input checked="" type="radio"/>	<5%	Note Payable	Pg20 5a2	63,723	63,723
Athena Health Care Systems	135 South Rd, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	>50%	Management Fee	Pg 17	420,000	358,095

\* 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 Newtown Rehabilitation & Health Care Center	License No. 10207	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.

Not Applicable: No Non-Nursing Home Cost Centers

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

Name of Facility Newtown Rehabilitation & Health Ca	License No. 10207	Report for Year Ended 9/30/2023	Page 6	of 37
Square footage of entire facility. <span style="float:right; border: 1px solid black; padding: 2px;">0</span>				
<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 Newtown Rehabilitati	License No. 10207	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 Newtown Rehabilitation & Health Care Center			License No. 10207		Report for Year Ended 9/30/2023				Page 8	of 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	154	154			154	154						
B. On last day of THIS report period	154	154							154	154		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	125	125			125	125						
B. As of midnight of THIS report period	89	89							89	89		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,175	4,175			3,662	3,662			513	513		
B. Medicaid (Conn.)	29,727	29,727			22,811	22,811			6,916	6,916		
C. Medicaid (other states)												
D. Private Pay	3,598	3,598			2,848	2,848			750	750		
E. State SSI for RCH												
F. Other (Specify)	187	187			187	187						
G. Total Care Days During Period (3A thru F)	37,687	37,687			29,508	29,508			8,179	8,179		
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	42	42			42	42						
5. <b>Total Resident Days (3G + 4A + 4B)</b>	37,729	37,729			29,550	29,550			8,179	8,179		

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

Name of Facility Newtown Rehabilitation & Health Care Center	License No. 10207	Report for Year Ended 9/30/2023	Page 9	of 37
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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)	(Specify)	Lost			Gained			CCNH / RHNS	(Specify)	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH / RHNS	(Specify)	(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)	(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	4	76		5		4		
Per Diem Rate								
a. One bed rm.	600.36	#####		616.00		418.89		
b. Two bed rms.	600.36	#####		567.00		419.00		
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B	10,393	10,393			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	900	900			
2. Restorative Treatments					
C. Other	5,165	5,165			
<b>D. Total Physical Therapy Treatments</b>	<b>16,458</b>	<b>16,458</b>			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	1,956	1,956			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	103	103			
2. Restorative Treatments					
C. Other	1,540	1,540			
<b>D. Total Speech Therapy Treatments</b>	<b>3,599</b>	<b>3,599</b>			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	8,498	8,498			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	861	861			
2. Restorative Treatments	7,478	7,478			
C. Other					
<b>D. Total Occupational Therapy Treatments</b>	<b>16,837</b>	<b>16,837</b>			

Annual Report of Long-Term Care Facility

CSP-10 Rev. 3/2023

Report of Expenditures - Salaries & Wages

Name of Facility Newtown Rehabilitation & Health Care Center	License No. 10207	Report for Year Ended 9/30/2023	Page 10	of 37
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Are time records maintained by all individuals receiving compensation?  Yes  No

Item	Total Cost and Hours									
	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	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)	153,502									
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)			#REF!							
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	361,458		13,307							
5. Dietary Service										
a. Head Dietitian	62,968		1,629							
b. Food Service Supervisor	79,635		2,038							
c. Dietary Workers	591,129		27,899							
6. Housekeeping Service										
a. Head Housekeeper	65,909		2,150							
b. Other Housekeeping Workers	315,567		18,299							
7. Repairs & Maintenance Services										
a. Engineer or Chief of Maintenance	79,229		2,118							
b. Other Maintenance Workers	64,362		2,181							
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	284,487		2,922							
b. RN										
1. Direct Care	862,258		15,327							
2. Administrative**	563,205		14,269							
c. LPN										
1. Direct Care	1,822,991		41,155							
2. Administrative**										
d. Aides and Attendants	2,403,499		86,260							
e. Physical Therapists	436,222		10,704							
f. Speech Therapists	209,934		4,826							
g. Occupational Therapists	320,480	(320,480)	7,955							
h. Recreation Workers	296,138		10,848							
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	310,961	(14,574)	8,974							
n. Marketing										
o. Other (Specify) See Attached Schedule										
A-13. Total Salary Expenditures	9,283,934	(335,054)	275,069							

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

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

\*\*\* This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed 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	
Newtown Rehabilitation & Health Care Center				10207	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	
Newtown Rehabilitation & Health Care Center				10207	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>										
Joanne Gabriel (1/18/23-8/22/23)	83,832			Health and life insurance, Payroll Taxes.	Day to Day operations of the nursing home facility.	1,240	A2			
Antonio Porcheddu (8/22/23-9/30/23) License #2120	19,346			Health and life insurance, Payroll Taxes.	Day to Day operations of the nursing home facility.	254	A2			
Freddie Diaz (10/10/22-1/18/23) Stephanie Vitko-Aniolek (10/1/22-10/8/22)	50,324			Health and life insurance, Payroll Taxes.	Day to Day operations of the nursing home facility.	714	A2			
<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
Newtown Rehabilitation & Health Care Center	10207	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	477		21						
3. Pharmacist	14,222		245						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	5,587		15						
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	54,008		240						
b. Utilization Review (Title 18 and 19 only) monthly meeting									
c. Resident Care**	1,170	(1,170)	20						
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									
b. Other									
10. Occupational Therapist									
a. Resident Care									
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	306,174		3,530						
2. Administrative***	211,951		1,060						
b. LPN									
1. Direct Care	214,294		2,672						
2. Administrative***									
c. Aides	338,437		6,248						
d. Other									
12. Other (Specify) See Attached Schedule									
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>1,146,320</b>	<b>(1,170)</b>	<b>14,051</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 Newtown Rehabilitation & Health Care Center		License No. 10207	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			
AAA Nursing Care, LLC, 3303 Main Street, Stratford, CT 06614	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Nurse Network, Access Capital, 405 Park Avenue, New York, NY 10022	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Comprehensive Rehab Consultants, 275 Madison Ave., Suite 1916, New York, NY 1006	Physical Therapy	<input type="radio"/>	<input checked="" type="radio"/>			
Procure LTC, 111 Executive Blvd, Farmingdale, NY 11735	Pharmacist	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners: Minority Interest		
Robert Larosa, DDS, 375 Main Street, Woodbury, CT 06798	Dental	<input type="radio"/>	<input checked="" type="radio"/>			
Health Drive Dental Group, 100 Crossing Blvd., Framingham, MA 01702	Dental	<input type="radio"/>	<input checked="" type="radio"/>			
SDX Dysphagia Experts, 21 Waterville Road, Avon, CT 06001	Speech Therapy	<input type="radio"/>	<input checked="" type="radio"/>			
Quotidian, 52 Senff Road, Washington, CT 06793	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
Ortho CT, PC, 2 riverview Drive, Danbury, CT 06810	Physician	<input type="radio"/>	<input checked="" type="radio"/>			
Orthopaedic Specialty Group, 305 Blackrock Tpke, Fairfield, CT 06830	Physician	<input type="radio"/>	<input checked="" type="radio"/>			
Orthopaedic Specialists of CT, 60 Old New Milford Road, Brookfield, CT 06804	Physician	<input type="radio"/>	<input checked="" type="radio"/>			
Ortho Connecticut, PO Box 26303, Oklahoma City, OK 73126	Physician	<input type="radio"/>	<input checked="" type="radio"/>			
Dedicated Nursing Association, 6536 William Penn Highway, Suite 201, Delmont, PA 15626-	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
AAA Nursing Care, LLC, 3303 Main Street, Stratford, CT 06614	Nurse Pool	<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
Newtown Rehabilitation & Health Care Center	10207	9/30/2023					15	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
<b>1. Administrative and General</b>								
<b>a. Employee Health &amp; Welfare Benefits</b>								
1. Workmen's Compensation	\$ 140,706	140,706						
2. Disability Insurance	\$							
3. Unemployment Insurance	\$ 73,891	73,891						
4. Social Security (F.I.C.A.)	\$ 676,813	676,813						
5. Health Insurance	\$ 880,680	880,680						
6. Life Insurance (employees only) (not-owners and not-operators)	\$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 93,185	93,185						
8. Uniform Allowance	\$ 9,918	9,918						
9. Other ( <i>Specify</i> ) See Attached Schedule	\$							
<b>b. Personal Retirement Plans, Pensions, and         Profit Sharing Plans for Owners and         Operators (Discriminatory)*</b>	\$							
<b>c. Bad Debts*</b>	\$	223,247	(223,247)					
<b>d. Accounting and Auditing</b>	\$ 3,737	4,638	(901)					
<b>e. Legal (<i>Services should be fully described on Page 15b</i>)</b>	\$	65,669	(65,669)					
<b>f. Insurance on Lives of Owners and         Operators (<i>Specify</i>)*</b>	\$							
<b>g. Office Supplies</b>	\$ 105,096	105,096						
<b>h. Telephone and Cellular Phones</b>								
1. Telephone & Pagers	\$ 17,022	17,022						
2. Cellular Phones	\$ 720	1,570	(850)					
<b>i. Appraisal (<i>Specify purpose and         attach copy</i>)*</b>	\$							
<b>j. Corporation Business Taxes (<i>franchise tax</i>)</b>	\$							
<b>k. Other Taxes (<i>Not related to property - See Page 22</i>)</b>								
1. Income*	\$							
2. Other ( <i>Specify</i> ) See Attached Schedule	\$							
3. Resident Day User Fee	\$ 704,401	704,401						
<b>Subtotal</b>	\$ 2,706,169	2,996,836	(290,667)					

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

(Carry Subtotals forward to next page)



## General Information and Questionnaire

### Accounting Basis

Name of Facility Newtown Rehabilitation & Health	License No. 10207	Report for Year Ended 9/30/2023	Page 15b	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual     Cash     Modified Cash

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

**Independent Accounting Firm**

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1    Marcum, L.L.P.	555 Long Wharf Dr., New Haven, CT
2    CJLC LLC	225 Pitkin Street, East Hartford, CT
3	
4	

Services Provided by This Firm (*describe fully*)

1    Medicare Cost Reports - allowed	\$	2,835
2    Tax Return - allowed	\$	902
3    Tax Return - Landlord (Disallowed)	\$	901
4	\$	
		<b>Charge for Services Provided</b>
		\$            4,638

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

Yes     No    Pg 15, Line 1d

**Legal Services Information**

Name of Legal Firm or Independent Attorney	Telephone Number
1    Goldman, Gruder & Woods, LLC Pilicy & Ryan	203-899-8900/ 203-364-3388
2    Connecticut State Marshal Office	790-7656
3    Murtha, Cullina, LLP	203-772-7700
4    Jackson Lewis P.C.	860-522-0404
5    Stephen Woods & Treasurer, State of CT	203-794-8508

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

- 1    200 Connecticut Avenue, Norwalk, CT PO Box 5505, Newtown, CT 06470
- 2    P.O. Box 371, Danbury, CT 06813
- 3    265 Church St., New Haven, CT
- 4    90 State House Square, 8th Floor, Hartford, CT 06103
- 5    PO Box 371 Danbury, CT/ 1 School St, Bethel, CT

Services Provided by This Firm (*describe fully*)

1    Collections - Disallowed	\$	63,333
2    PPP Loan - disallowed	\$	2,336
3	\$	
4	\$	
5	\$	
		<b>Charge for Services Provided</b>
		\$            65,669

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

Yes     No    Pg.15, Line 1e

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

Name of Facility	License No.	Report for Year Ended					Page	of
Newtown Rehabilitation & Health Care Center	10207	9/30/2023					16	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
<b>Subtotals Brought Forward:</b>	2,706,169	2,996,836	(290,667)					
<b>l. Travel and Entertainment</b>								
1. Resident Travel and Entertainment \$								
2. Holiday Parties for Staff \$	3,160	3,160						
3. Gifts to Staff and Residents \$	12,882	12,882						
4. Employee Travel \$	461	461						
5. Education Expenses Related to Seminars and Conventions \$	4,879	4,879						
6. Automobile Expense ( <i>not purchase or depreciation</i> ) \$	10,538	10,538						
7. Other ( <i>Specify</i> ) See Attached Schedule \$								
<b>m. Other Administrative and General Expenses</b>								
1. Advertising Help Wanted ( <i>all such expenses</i> ) \$	27,226	27,226						
2. Advertising Telephone Directory ( <i>all such expenses</i> )*** \$								
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule \$		5,600	(5,600)					
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 \$	6,638	6,638						
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule \$	9,189	9,189						
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.*** \$								
9. Subscriptions \$	175	175						
10. Contributions*** See Attached Schedule \$		200	(200)					
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> ) \$								
12. Administrative Management Services** \$	253,944	294,802	(40,858)					
13. Other ( <i>Specify</i> ) See Attached Schedule \$	140,786	248,021	(107,235)					
<b>C-14 Total Administrative &amp; General Expenditures</b> \$	3,176,047	3,620,607	(444,560)					

\* 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	\$ 5,600	\$ (5,600)				
<b>Total Other Advertising</b>	\$ 5,600	\$ (5,600)	\$ -	\$ -	\$ -	\$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
CAHCF	\$ 9,189					
<b>Total Dues</b>	\$ 9,189	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
CAHCF - Inaugural Ball	\$ 200	\$ (200)				
<b>Total Contributions</b>	\$ 200	\$ (200)	\$ -	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Bank charges	\$ 28,556	\$ (28,556)				
Payroll Processing Fees	\$ 23,271					
Employee Physicals	\$ 13,296					
Data Processing	\$ 83,083					
Energy Audit	\$ 21,136					
CMS Penalty 2023-01-LTC-331	\$ 78,679	\$ (78,679)				
<b>Total Other Administrative and General</b>	\$ 248,021	\$ (107,235)	\$ -	\$ -	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Newtown Rehabilitation & Health Care C	10207	9/30/2023	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	446,670		See Below
	294,802	Admin/Gen 66%	Pg 16, Line 12
	71,467	Indirect 16%	Pg 18, Line 2C
	80,401	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.**

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

Name of Facility		License No.	Report for Year Ended				Page	of
Newtown Rehabilitation & Health Care Center		10207	9/30/2023				18	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	\$ 377,502	377,502						
2. Non-Food Supplies	\$ 52,059	52,059						
3. Other (Specify) _____ Dishes	\$ 2,982	2,982						
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$							
c. Other (Specify) _____ Management Services Temp Help	\$ 71,607	71,607						
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 504,150</b>	<b>504,150</b>						
2E. Dietary Questionnaire		Total	CCNH / RHNS		(Specify)	(Specify)		
F. Resident Meals: Total no. of meals served per day:*	310	310						
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 checked="" type="radio"/> Yes	<input type="radio"/> No			If yes, specify cost.			
K. Is any revenue collected from these people?	<input checked="" type="radio"/> Yes	<input type="radio"/> No			If yes, specify amt.	32094		
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)						Pg 30, IV 1		
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<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
Newtown Rehabilitation & Health Care Center		10207	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. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.							
	Amt. \$							
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.							
	Amt. \$							
4. Repair and/or purchase of linens.***	Lbs.							
	Amt. \$	1,816	1,816					
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$	182,335	182,335					
c. Other (Specify) Supplies	\$	1,772	1,772					
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	<b>\$</b>	<b>185,923</b>	<b>185,923</b>					
<b>3E. Laundry Questionnaire</b>								
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
Newtown Rehabilitation & Health Care Center		10207	9/30/2023				20	37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4.	Housekeeping							
	a. In-House Care	Sq. Ft. Serviced by Personnel						
	1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	54,969	54,969				
	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. \$						
	C. Other ( <i>Specify</i> )	\$						
4D.	<b>Total Housekeeping Expenditures</b> (4a + b + c)	\$	54,969	54,969				
5.	Resident Care (Supplies)**							
	a. Prescription Drugs***							
	1. Own Pharmacy	\$						
	2. Purchased from ProCare LTC	\$		224,216	(224,216)			
	b. Medicine Cabinet Drugs	\$	17,525	17,525				
	c. Medical and Therapeutic Supplies	\$	301,992	322,866	(20,874)			
	d. Ambulance/Limousine***	\$		3,190	(3,190)			
	e. Oxygen							
	1. For Emergency Use	\$						
	2. Other***	\$		12,142	(12,142)			
	f. X-rays and Related Radiological Procedures***	\$		9,251	(9,251)			
	g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$						
	h. Laboratory***	\$		162,993	(162,993)			
	i. Recreation	\$	26,345	26,345				
	j. Direct Management Services*	\$	69,258	80,401	(11,143)			
	k. Indirect Management Services*	\$	(9,905)		(9,905)			
	l. Cable TV	\$	3,600	19,382	(15,782)			
	m. Other (Specify)**** See Attached Schedule	\$	57,496	58,290	(794)			
	n. Physical Therapy Expense	\$						
	o. Speech Therapy Expense	\$						
5P.	<b>Total Resident Care Expenditures</b> (5a - 5o)	\$	466,311	936,601	(470,290)			

\* 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 Newtown Rehabilitation & Health Care Center			License No. 10207		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
Procure LTC	111 Executive B;vd Farmingdale. NY 11735	<input type="radio"/>	<input checked="" type="radio"/>	Common Owners: Minority Interest	Pharmacy	294,869			20	5a2
R&P Tree Work	2nd Fl. Fanbury, CT 06810	<input type="radio"/>	<input checked="" type="radio"/>		Snowplowing/Landscaping	36,431			20	6f
All American Waste	PB Box 630, East Windsor, CT 06088	<input type="radio"/>	<input checked="" type="radio"/>		Rubbish Removal	36,140			22	6f
ADP	PO Box 842875 Boston, MA 02284	<input type="radio"/>	<input checked="" type="radio"/>		Payroll services	18,331			16	m13
		<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"/>							

\* 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
Newtown Rehabilitation & Health Care Center	10207	9/30/2023					22	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	\$ 242,147	242,147						
b. Heat	\$ 111,060	111,060						
c. Light & Power	\$ 163,113	163,113						
d. Water	\$ 7,900	7,900						
e. Equipment Lease ( <i>Provide detail on page 22b</i> )	\$ 41,981	41,981						
f. Other ( <i>itemize</i> )	\$ 102,934	102,934						
See Attached Schedule								
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	\$ 669,135	669,135						
7. Depreciation ( <i>complete schedule page 23*</i> )								
a. Land Improvements	\$							
b. Building & Building Improvements	\$							
c. Non-Movable Equipment	\$							
d. Movable Equipment	\$ 92,127	92,127						
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	\$ 92,127	92,127						
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )								
a. Organization Expense	\$ 266,235	266,235						
b. Mortgage Expense	\$							
c. Leasehold Improvements	\$ 3,906	3,906						
d. Other ( <i>Specify</i> )	\$							
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	\$ 270,141	270,141						
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 801,555	801,555						
10. Property Taxes								
a. Real estate taxes paid by owner	\$							
b. Real estate taxes paid by lessor	\$ 243,645	243,645						
c. Personal property taxes	\$ 9,318	9,318						
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	\$ 1,416,786	1,416,786						

\* 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
Newtown Rehabilitation & Health Care Center			10207	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						
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	<input type="radio"/>	<input checked="" type="radio"/>	Postal Equipment	04/28/21	36 months	771	771	
Leaf	<input type="radio"/>	<input checked="" type="radio"/>	copiers	02/28/22	48 months	15,768	7,327	
Cannon Solutions One Canon Park, Melville, NY 11747	<input type="radio"/>	<input checked="" type="radio"/>	copiers	06/01/18	40 months	17,300	17,300	
Cannon Solutions One Canon Park, Melville, NY 11747	<input type="radio"/>	<input checked="" type="radio"/>	copiers	06/01/18	40 months	6,624	6,560	
	<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>Is a Mileage Log Book Maintained for All Leased Vehicles ?</b>							<input type="radio"/> Yes	<input type="radio"/> No
<b>Total ***</b>							31,958	

\* 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 Newtown Rehabilitation & Health Care Center			License No. 10207		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													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal													
<b>C. Non-Movable Equipment</b>													
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							
<b>D. Movable Equipment</b>													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a.			yes		6	18	30,000	30,000	27,000	S/L	5	3,000	
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period					9	2022	929,960	929,960	757,217	S/L	Various	87,944	
b. Disposals (attach schedule)													
Acquired during this report period (attach schedule):													
c. Administrative					9	2023	2,164	2,164		s/l	Var	108	
d. Standard Resident					9	2023	19,366	19,366		s/l	Var	1,075	
e. Specialized Resident													
Total Acquired during this report period							21,530	21,530				1,183	
D-3. Subtotal													92,127
<b>E. Total Depreciation</b>													92,127



## 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>					
		Standard Resident			
		Administrative			
		Standard Resident			
		Standard Resident			
3/31/2023	refrigerator 29" glass door	Standard Resident	\$ 2,784	10	\$ 139
4/30/2023	4 chairs/ 4 benches	Standard Resident	\$ 6,065	15	\$ 202
10/31/2022	5 tvs and cables	Standard Resident	\$ 2,731	5	\$ 273
3/31/2023	6 32" tv's	Standard Resident	\$ 1,434	5	\$ 143
1/31/2023	6 office chairs	Administrative	\$ 2,164	10	\$ 108
1/31/2023	glass door refrigerator	Standard Resident	\$ 2,639	10	\$ 132
1/31/2023	12 matrix bed & control box	Standard Resident	\$ 3,713	10	\$ 186
<b>Total additions for Movable Equipment</b>			\$ 21,530		\$ 1,183 *
<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
1/31/2023	replacement recirc pump 1/2	\$ 2,845	10	\$ 142
1/31/2023	replacement recirc pump 1/2	\$ 2,845	10	\$ 142
1/31/2023	replace water pump	\$ 5,443	10	\$ 272
1/31/2023	replace fair pulley hubs	\$ 14,214	15	\$ 474
6/30/2023	door	\$ 7,158	15	\$ 239
8/31/2023	5 failed condensor motors	\$ 15,952	10	\$ 798
9/30/2023	hot water plate heat exchangers	\$ 7,338	10	\$ 367
9/30/2023	replace sewer line	24706	25	494
<b>Total additions for Leasehold Improvement</b>		\$ 80,501		\$ 2,928 *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</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			License No.		Report for Year Ended			Page	of
Newtown Rehabilitation & Health Care Center			10207		9/30/2023			24	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. Start Up	6	2018	10 Years	2,635,133	1,144,590			266,235	
2.									
3.									
A-4. Subtotal									266,235
<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	9	2022	Var	7,418	371		Var	978	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2023	Var	80,501		s/l	Var	2,928	
C-4. Subtotal									3,906
<b>D. Total Amortization</b>									270,141

\* 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 Newtown Rehabilitation & Health Care	License No. 10207	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					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	154				
6. Square Footage					
7. Acquisition Cost					
a. Land					
b. Building					
<b>Part B - Owner and Related Parties</b>		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)	Conventional				
b. Date Mortgage Obtained	06/01/18				
c. Interest Rate for the Cost Year	6.18%				
d. Term of Mortgage (number of years)	4 Years				
e. Amount of Principal Borrowed	13,500,00				
f. Principal balance outstanding as of _____					
<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
Newtown Rehabilitation & Health Ca		10207	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	
Newtown Rehabilitation & Health		10207		9/30/2023				27	37	
Item				Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:										
12. C. Movable Equipment										
1. Automotive Equipment				\$						
A. Item		Rate	Amount							
Lender										
Address of Lender										
2. Other (Specify)				\$	454	454				
A. Item		Rate	Amount							
phone system										
Lender										
Var Tech										
Address of Lender										
PO Box 10306, Des Moines										
B. Item		Rate	Amount							
Lender										
Address of Lender										
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$	454	454				
12. D. Other Interest Expense (Specify)				\$	23,031	23,031				
Vendor Interest										
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	23,485	23,485				
14. Insurance										
a. Insurance on Property (buildings only)				\$	172,242	172,242				
b. Insurance on Automobiles				\$	520	520				
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)				\$	172,762	172,762				
15. Total All Expenditures (A-13 thru C-14)				\$	16,763,598	18,014,672	(1,251,074)			

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended		Page	of
Newtown Rehabilitation & Health Care C 10207		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> )	\$ 16,747,135	16,747,135			
b. Medicaid Room and Board Contractual Allowance **	\$ (7,795,134)	(7,795,134)			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 1,238,568	1,238,568			
b. Medicare Room and Board Contractual Allowance **	\$ 365,429	365,429			
4. a. Private-Pay Residents and Other	\$ 3,422,941	3,422,941			
b. Private-Pay Room and Board Contractual Allowance **	\$ (433,270)	(433,270)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 88,544	88,544			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (88,544)	(88,544)			
c. Prescription Drugs - Non-Medicare	\$ 153,600	153,600			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (153,600)	(153,600)			
2. a. Medical Supplies - Medicare	\$ 7,174	7,174			
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$ 1,469	1,469			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (1,469)	(1,469)			
3. a. Physical Therapy - Medicare	\$ 872,161	872,161			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (240,150)	(240,150)			
c. Physical Therapy - Non-Medicare	\$ 238,750	238,750			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (238,750)	(238,750)			
4. a. Speech Therapy - Medicare	\$ 355,292	355,292			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (116,252)	(116,252)			
c. Speech Therapy - Non-Medicare	\$ 105,417	105,417			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (105,417)	(105,417)			
5. a. Occupational Therapy - Medicare	\$ 695,217	695,217			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (215,950)	(215,950)			
c. Occupational Therapy - Non-Medicare	\$ 235,050	235,050			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (235,050)	(235,050)			
6. a. Other ( <i>Specify</i> ) - Medicare	\$				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ (740,047)	(740,047)			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 14,163,114	14,163,114			
<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> )	\$ 194,533	194,533			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 58,983	58,983			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 253,516	253,516			
<b>VI. Total All Revenue</b> (III +V)	\$ 14,416,630	14,416,630			

\* 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)
<b>Total Other Resident Revenue - Medicare</b>		\$ -	\$ -	\$ -

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

**Related Exp**

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
N/A	Retroactives	\$ (740,047)		
<b>Total Other Resident Revenue</b>		\$ (740,047)	\$ -	\$ -

**Interest Income**

**Account**

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	(Specify)
pg 31 A2	interst on A/R		\$ 1,387		
pg 31 A2	ERC interest		\$ 193,146		
<b>Total Interest Income</b>			\$ 194,533	\$ -	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
NA	Bad Debt recovery	\$ 58,983		
<b>Total Other Revenue</b>		\$ 58,983	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care	10207	9/30/2023	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	20,357
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,608,954
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	25,545
5. Prepaid Expenses			\$	102,942
a. Prepaid Expenses	98,235			
b. Prepaid Insurance	4,707			
c. _____				
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)			\$	2,757,798
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 <u>87,919</u>		\$	83,642
	Accum. Depreciation <u>4,277</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>951,490</u>		\$	105,146
	Accum. Depreciation <u>846,344</u>	Net		
7. Motor Vehicles	*Historical Cost <u>30,000</u>		\$	
	Accum. Depreciation <u>30,000</u>	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
_____				
See Schedule				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	188,788

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			\$ -

Schedule of Other Current Assets (itemize) 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	
Total Other Other Fixed Assets (Itemize)			\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Deposits - Other	\$ 533
Total Other Assets			\$ 533

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)			\$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care	10207	9/30/2023	32	37
Account			Amount	
Total Brought Forward:			\$	2,946,586
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 <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	2,635,133		
	Accum. Depreciation	1,410,825	Net	\$ 1,224,308
4. Goodwill (Purchased Only)			\$	141,873
5. Investments Related to Resident Care ( <i>itemize</i> )			\$	
_____				
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	
Name and Address	Amount	Loan Date		
7. Other Assets ( <i>itemize</i> )			\$	137,472
	Deposit - Utilities - Other	6,479		
	Project Development	130,460		
	See Schedule	533		
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	1,503,653
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$	4,450,239

\* 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 Newtown Rehabilitation & Health Care Center		License No. 10207	Report for Year Ended 9/30/2023	Page 33	of 37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	2,504,822
2. Notes Payable ( <i>itemize</i> )				\$	
_____					
_____					
See Schedule					
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$	403,013
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	199,242
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable ( <i>Current Portion</i> )				\$	
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities ( <i>itemize</i> )				\$	3,060,882
Acc'd Operating Expense		409,441			
Acc'd Expense - CT Sales tax		479			
Due to Medicaid - Provider tax		2,619,260			
Acc'd Exp - Real Estate Tax		31,702	See Schedule		
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>				<b>\$</b>	<b>6,167,959</b>

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

(Carry Total forward to next page)

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

Name of Facility Newtown Rehabilitation & Health Care Cen		License No. 10207	Report for Year Ended 9/30/2023	Page 34	of 37
Account				Amount	
Total Brought Forward:				6,167,959	
<b>Liabilities (cont'd)</b>					
B. Long-Term Liabilities					
1. Loans Payable-Equipment ( <i>itemize</i> )					
				\$	3,551
Name of Lender	Purpose	Amount	Date Due		
Moveable equipment lease					
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$	783,774
Name and Address of Lender	Amount	Loan Date			
due to related party	669,153	none			
due to affiliates	114,621	none			
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$	65,518
Note Payable - Proare CT		65,518			
See Schedule					
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$	852,843
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$	7,020,802



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

Name of Facility	License No.	Report for Year Ended	Page	of
Newtown Rehabilitation & Health Care	10207	9/30/2023	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			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	500,000
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	527,479
6. Gain or Loss for Period			\$	(3,598,042)
	10/1/2022	thru	9/30/2023	
7. Total Net Worth			\$	(2,570,563)
<b>C. Total Reserves and Net Worth</b>			\$	(2,570,563)
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	4,450,239

### H. Changes in Total Net Worth

Name of Facility Newtown Rehabilitation & Health Care C	License No. 10207	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			\$	(2,097,690)		
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$	14,416,630		
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$	18,014,672		
D. Net Income or Deficit			\$	(3,598,042)		
E. Balance			\$	(5,695,732)		
F. Additions						
1. Additional Capital Contributed ( <i>itemize</i> )						
ERC	3,125,169					
2. Other ( <i>itemize</i> )						
F-3. Total Additions					\$	3,125,169
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>Balance at End of Period</b>			\$	(2,570,563)		

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

Name of Facility Newtown Rehabilitation & Health Care	License No. 10207	Report for Year Ended 9/30/2023	Page 37	of 37
<i>Check appropriate category</i>				
Chronic and Convalescent Nursing <input checked="" type="checkbox"/> 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	Date Signed		
Printed Name of Preparer				
Athena Health Care Systems				
Address Address		Phone Number		
135 South Rd Farmington, CT 06032		860-751-3900		
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number		
Amanda Doncet		860-751-3900		
Contact Email Address				
adoncet@athenahealthcare.com				