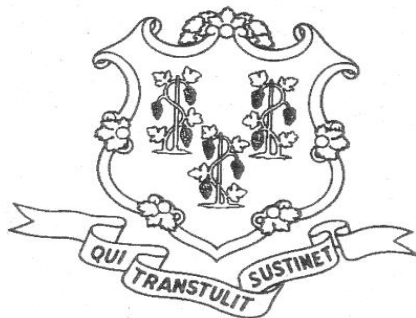


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2023

Name of Facility (as licensed) Montowese Health & Rehabilitation Center	
Address (No. & Street, City, State, Zip Code) 163 Quinnipiac Avenue, North Haven, CT 06473	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input 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 2442	(Specify)	(Specify)	Medicare Provider 07-5017
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Medicaid Provider Numbers:	CCNH / RHNS 10157	(Specify)	(Specify)
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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2023	1	37

Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR 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 Montowese Health & Rehabilitation 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) Joanne Gabriel			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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Montowese Health & Rehabilitation Center		Period Covered:	From 10/1/2022	To 9/30/2023
Address of Facility 163 Quinnipiac Avenue, North Haven, CT 06473				
Report Prepared By		Phone Number	Date	
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. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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) Montowese Health & Rehabilitation Center		Address (No. & Street, City, State, Zip) 163 Quinnipiac Avenue, North Haven, CT 06473			
License Numbers:	CCNH / RHNS 2442	(Specify)	(Specify)	Medicare Provider No. 07-5017	
Type of Facility (Check appropriate box(es)) Chronic and Convalescent <input 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.					
Administrator					
Name of Administrator Julia Oenechuk			Nursing Home Administrator's License No.:	2195	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		

**General Information and Questionnaire
 Related Parties***

Name of Facility Montowese Health & Rehabilitation Center	License No. 2442	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 401k Plan	135 South Rd, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Facility participates in common 401k plan			
Athena Health care System	135 South Rd, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	>50%	See attached			
Procare Pharmacy	111 Executive Blvd, Farmingdale, NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	<5%	Pharmacy Services	Pg 20 5a2, 5b	761,207	761,207
Procare Pharmacy	111 Executive Blvd, Farmingdale, NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	<5%	Notes Payable	Pg34 B4, Pg 27 12D	146,795	146,795
		<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.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Montowese Health & Rehabilitation Center	License No. 2442	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.

N/A

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 Montowese Health & Rehabilitation C	License No. 2442	Report for Year Ended 9/30/2023	Page 6	of 37
Square footage of entire facility.		45,174		
Outpatient Therapy				
Does the Facility provide outpatient therapy services?		No		
<i>If yes, please complete the following:</i>				
Square footage of therapy space.				
Meals on Wheels				
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				
Apartments, Independent Living, Assisted Living				
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 Montowese Health &	License No. 2442	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 Montowese Health & Rehabilitation Center			License No. 2442		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	120	120			120	120						
B. On last day of THIS report period	120	120							120	120		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	109	109			109	109						
B. As of midnight of THIS report period	94	94							94	94		
3. Total Number of Days Care Provided During Period												
A. Medicare	12,485	12,485			9,646	9,646			2,839	2,839		
B. Medicaid (Conn.)	22,471	22,471			16,515	16,515			5,956	5,956		
C. Medicaid (other states)												
D. Private Pay	1,515	1,515			1,385	1,385			130	130		
E. State SSI for RCH												
F. Other (Specify) Managed Care	866	866			670	670			196	196		
G. Total Care Days During Period (3A thru F)	37,337	37,337			28,216	28,216			9,121	9,121		
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	5	5			5	5						
5. Total Resident Days (3G + 4A + 4B)	37,342	37,342			28,221	28,221			9,121	9,121		

Schedule of Resident Statistics (Cont'd)

Name of Facility Montowese Health & Rehabilitation Center			License No. 2442			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)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	(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	9	66		1		18						
Per Diem Rate												
a. One bed rm.	577.66	#####				360.45						
b. Two bed rms.	577.66	#####				360.45						
c. Three or more bed rms.	577.66	#####				360.45						
7. Total Number of Physical Therapy Treatments				TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)				
A. Medicare - Part B				14,207	14,207							
B. Medicaid (Exclusive of Part B)												
1. Maintenance Treatments				4,707	4,707							
2. Restorative Treatments												
C. Other				27,590	27,590							
D. Total Physical Therapy Treatments				46,504	46,504							
8. Total Number of Speech Therapy Treatments												
A. Medicare - Part B				1,686	1,686							
B. Medicaid (Exclusive of Part B)												
1. Maintenance Treatments				364	364							
2. Restorative Treatments												
C. Other				1,889	1,889							
D. Total Speech Therapy Treatments				3,939	3,939							
9. Total Number of Occupational Therapy Treatments												
A. Medicare - Part B				14,875	14,875							
B. Medicaid (Exclusive of Part B)												
1. Maintenance Treatments				4,295	4,295							
2. Restorative Treatments												
C. Other				27,436	27,436							
D. Total Occupational Therapy Treatments				46,606	46,606							

Annual Report of Long-Term Care Facility

CSP-10 Rev. 3/2023

Report of Expenditures - Salaries & Wages

Name of Facility Montowese Health & Rehabilitation Center	License No. 2442	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)	147,356		2,004							
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)										
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	343,179		12,032							
5. Dietary Service										
a. Head Dietitian	87,168		2,089							
b. Food Service Supervisor	99,707		2,229							
c. Dietary Workers	477,707		25,263							
6. Housekeeping Service										
a. Head Housekeeper	57,658		1,848							
b. Other Housekeeping Workers	358,272		20,225							
7. Repairs & Maintenance Services										
a. Engineer or Chief of Maintenance	129,090		3,270							
b. Other Maintenance Workers	70,282		3,281							
8. Laundry Service										
a. Supervisor										
b. Other Laundry Workers	155,585		8,830							
9. Barber and Beautician Services										
10. Protective Services	37,503		2,102							
11. Accounting Services										
a. Head Accountant										
b. Other Accountants										
12. Professional Care of Residents										
a. Directors and Assistant Director of Nurses	207,493		3,159							
b. RN										
1. Direct Care	488,532		9,413							
2. Administrative**	950,126		25,518							
c. LPN										
1. Direct Care	2,298,477		53,970							
2. Administrative**										
d. Aides and Attendants	2,148,408		88,713							
e. Physical Therapists	1,113,790		28,456							
f. Speech Therapists	175,886		4,140							
g. Occupational Therapists	749,281	(749,281)	18,523							
h. Recreation Workers	199,799		7,567							
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	503,041	(25,038)	15,737							
n. Marketing										
o. Other (Specify) See Attached Schedule										
A-13. Total Salary Expenditures	10,798,340	(774,319)	338,369							

* 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	
Montowese Health & Rehabilitation Center				2442	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)							
Section I - Operators/Owners										
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).										

* 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	
Montowese Health & Rehabilitation Center				2442	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)							
Section III - Administrators***										
Patrick McDonnell 10/1/22-7/13/23	125,195			Health & Life Insurance, Payroll Taxes	Day to day operations if the nursing home facility	1,656	A2	Glastonbury Health Care	160	11,923
Carol Anne Salviotti 7/14/23-7/30/23				Health & Life Insurance, Payroll Taxes	Day to day operations if the nursing home facility		A2	Athena Health Care 135 South Rd, Farmington, CT 06032		
Julie Olenechuk 7/31/23-9/30/23	22,161			Health & Life Insurance, Payroll Taxes	Day to day operations if the nursing home facility	348	A2			
Section IV - Assistant Administrators										

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

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

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

Annual Report of Long-Term Care Facility

CSP-13 Rev. 3/2023

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended						Page	of
Montowese Health & Rehabilitation Center	2442	9/30/2023						13	37
Total Cost and Hours									
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)									
1. Dietitian									
2. Dentist	1,890		7						
3. Pharmacist	15,494		182						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care									
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	62,500		225						
b. Utilization Review (Title 18 and 19 only) monthly meeting									
c. Resident Care**	878	(878)							
d. Administrative Services facility									
1. Infection Control Committee (Quarterly meetings)									
2. Pharmaceutical Committee (Quarterly meetings)									
3. Staff Development Committee (Once annually)									
e. Other (Specify)	8,787		24						
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	77,583		789						
2. Administrative***									
b. LPN									
1. Direct Care	108,021		1,214						
2. Administrative***									
c. Aides	81,969		1,685						
d. Other									
12. Other (Specify) See Attached Schedule									
B-13 Total Fees Paid in Lieu of Salaries	357,122	(878)	4,126						

* 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 Montowese Health & Rehabilitation Center		License No. 2442	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		
Dr. Anuruddha Walaliyadda, 12 Cooke Road, Wallingford, CT 06492	Physician-Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Dharini Sun, 2690 Whitey Avenue, Hamden, CT 06518	Physician-Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Masstex, 3 Electronics Ave, Suite 210, Danvers, MA 01923	Speech Therapy	<input type="radio"/>	<input checked="" type="radio"/>		
Norton & Associates, 97 Elm St, Cohasset, MA 02025	RN, LPN, C.N.A. Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Solomon Page Staffing Solutions, 260 Madison Ave 4th Fl, New York, NY 10016	RN, LPN, C.N.A. Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Mas Medical Staffing, 156 Harvey Rd, Londonderry, NH 03053	RN, LPN, C.N.A. Pool	<input type="radio"/>	<input checked="" type="radio"/>		
SDX Dysphagia Experts, 21 Waterville Rd, Avon, CT 06001	Speech Therapy	<input type="radio"/>	<input checked="" type="radio"/>		
Nurse Network, 653 Main St, Plantsville, CT 06479	RN, LPN, C.N.A. Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Procure LTC Pharmacy, 110 Bi-County Blvd, Ste 121, Farmingdale, NY 11735	Pharmacist	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners: Minority Interest	
Marvel Medical Staffing, 156 Harvey Rd, Londonderry, NH 03053	LPN	<input type="radio"/>	<input checked="" type="radio"/>		
Prime Time Healthcare, PO Box 3544, Omaha, NE 68103	LPN, C.N.A. Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Health Drive 100 Crossing Blvd Suite 300 Framingham, MA 01702	Eye Care, Dental	<input type="radio"/>	<input checked="" type="radio"/>		
Sambacare, 410 Melville Ave, Lakewood, NJ 08701	LPN, C.N.A. Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Paramount Healthcare Services, Inc, 3 Courthouse Lane, Unit 2, Chelmsford, MA 01824	C.N.A. Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Worldwide Staffing, 2222 Wedwick Rd, Nurham, NC 27713	LPN, C.N.A. Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Fusion Medical, PO Box 30131, Omaha, NE 68103	C.N.A. Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Yale Medical PO Box 51818 Boston, MA 02241-8618	Physician	<input type="radio"/>	<input checked="" type="radio"/>		
Clipboard Health PO Box 103125 Pasadena, CA 91189	RN Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Staff on Tap 21 Waterville Rd, Avon, CT	C.N.A. 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"/>		

* 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
Montowese Health & Rehabilitation Center	2442	9/30/2023					15	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
I. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	\$ 288,613	288,613						
2. Disability Insurance	\$							
3. Unemployment Insurance	\$ 83,117	83,117						
4. Social Security (F.I.C.A.)	\$ 779,966	779,966						
5. Health Insurance	\$ 1,018,802	1,018,802						
6. Life Insurance (employees only) (not-owners and not-operators)	\$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 111,906	111,906						
8. Uniform Allowance	\$ 3,406	3,406						
9. Other (<i>Specify</i>) See Attached Schedule	\$							
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$							
c. Bad Debts*	\$	187,798	(187,798)					
d. Accounting and Auditing	\$ 2,835	3,736	(901)					
e. Legal (<i>Services should be fully described on Page 15b</i>)	\$	38,417	(38,417)					
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$							
g. Office Supplies	\$ 61,809	61,809						
h. Telephone and Cellular Phones								
1. Telephone & Pagers	\$ 19,162	19,162						
2. Cellular Phones	\$ 900	900						
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$							
j. Corporation Business Taxes (<i>franchise tax</i>)	\$							
k. Other Taxes (<i>Not related to property - See Page 22</i>)								
1. Income*	\$	67,962	(67,962)					
2. Other (<i>Specify</i>) See Attached Schedule	\$							
3. Resident Day User Fee	\$ 522,494	522,494						
Subtotal	\$ 2,893,010	3,188,088	(295,078)					

* 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 Montowese Health & Rehabilitation	License No. 2442	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, LLP	185 Asylum St, 17th Floor, Hartford, CT 06103
2 Marcum, LLP	185 Asylum St, 17th Floor, Hartford, CT 06103
3	
4	

Services Provided by This Firm (*describe fully*)

1 Medicare Cost Report	\$ 2,835
2 Sales Analysis: Disallow	\$ 901
3	\$
4	\$
	Charge for Services Provided
	\$ 3,736

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 Athena Health Care/Brenner Saltzman & Wallman	203-772-2600
2 Treasurer State of CT/Town of North Haven	
3 Goldman, Gruder & Woods/Pilicy & Ryan	203-899-8900
4 Jackson Lewis PC	914-872-8060
5	

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

1 271 Whitney Ave, New Haven, CT 06511
2
3 200 Connecticut Ave, Norwalk, CT 06854
4 44 South Broadway 14th Fl, White Plains, NY 10601
5

Services Provided by This Firm (*describe fully*)

1 PPP Loan Consulting: Disallow	\$ 2,112
2 Conservatorship: Disallow	\$ 1,428
3 Collections: Disallow	\$ 24,410
4 Employee Matters: Disallow	\$ 10,467
5	\$
	Charge for Services Provided
	\$ 38,417

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
Montowese Health & Rehabilitation Center	2442	9/30/2023				16	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:	2,893,010	3,188,088	(295,078)				
l. Travel and Entertainment							
1. Resident Travel and Entertainment \$							
2. Holiday Parties for Staff \$	3,680	3,680					
3. Gifts to Staff and Residents \$		9,979	(9,979)				
4. Employee Travel \$	10,229	10,229					
5. Education Expenses Related to Seminars and Conventions \$	3,576	3,576					
6. Automobile Expense (<i>not purchase or depreciation</i>) \$							
7. Other (<i>Specify</i>) \$ See Attached Schedule							
m. Other Administrative and General Expenses							
1. Advertising Help Wanted (<i>all such expenses</i>) \$	9,090	9,090					
2. Advertising Telephone Directory (<i>all such expenses</i>)*** \$							
3. Advertising Other (<i>Specify</i>)*** \$ See Attached Schedule		2,739	(2,739)				
4. Fund-Raising*** \$							
5. Medical Records \$							
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)*** \$							
7. Postage \$	4,029	4,029					
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) \$ See Attached Schedule	7,174	7,174					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.*** \$							
9. Subscriptions \$	940	940					
10. Contributions*** \$ See Attached Schedule							
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>) \$							
12. Administrative Management Services** \$	238,152	118,528	119,624				
13. Other (<i>Specify</i>) \$ See Attached Schedule	89,823	409,325	(319,502)				
C-14 Total Administrative & General Expenditures \$	3,259,703	3,767,377	(507,674)				

* 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
Total Other Travel and Entertainment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Promotional	\$ 2,739	\$ (2,739)				
Total Other Advertising	\$ 2,739	\$ (2,739)	\$ -	\$ -	\$ -	\$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
CAHCF Dues	\$ 7,174					
Total Dues	\$ 7,174	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Total Contributions	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Bank Charges	\$ 20,393	\$ (20,393)				
Payroll Processing Fees	\$ 28,295					
Employee Physicals/Background Checks	\$ 5,788					
Data Processing/ Software Maint. Fees	\$ 55,740					
Other Professional Fees	\$ 299,109	\$ (299,109)				
Total Other Administrative and General	\$ 409,325	\$ (319,502)	\$ -	\$ -	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Montowese Health & Rehabilitation Center	2442	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	179,588	Contract Attached to a Prior Year	See Below
Allocation of the above	118,528	Admin/Gen 66%	Pg 16, Line 12
Allocation of the above	28,734	Indirect 16%	Pg 20 Line 5k
Allocation of the above	32,326	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
Montowese Health & Rehabilitation Center		2442	9/30/2023				18	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	\$ 340,140	340,633	(493)					
2. Non-Food Supplies	\$ 39,108	39,108						
3. Other (Specify) _____ Dishes = \$5,601	\$ 5,601	5,601						
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$							
c. Other (Specify) _____ Management Services	\$ 28,734	28,734						
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 413,583	414,076	(493)					
2E. Dietary Questionnaire		Total	CCNH / RHNS		(Specify)	(Specify)		
F. Resident Meals: Total no. of meals served per day:*	307	307						
G. Is cost of employee meals included in 2D?	<input checked="" type="radio"/> Yes <input 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. 493			
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
Montowese Health & Rehabilitation Center		2442	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. \$	16,778	16,778					
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$							
c. Other (Specify) Supplies = \$4998	\$	4,998	4,998					
3D. Total Laundry Expenditures (3a + b + c)	\$	21,776	21,776					
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
Montowese Health & Rehabilitation Center		2442	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. \$	74,909	74,909				
	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.	Total Housekeeping Expenditures (4a + b + c)	\$	74,909	74,909				
5.	Resident Care (Supplies)**							
	a. Prescription Drugs***							
	1. Own Pharmacy	\$						
	2. Purchased from Procure Pharmacy	\$	755,332	(755,332)				
	b. Medicine Cabinet Drugs	\$	18,471	18,471				
	c. Medical and Therapeutic Supplies	\$	322,288	347,067	(24,779)			
	d. Ambulance/Limousine***	\$	10,541	(10,541)				
	e. Oxygen							
	1. For Emergency Use	\$						
	2. Other***	\$	15,159	(15,159)				
	f. X-rays and Related Radiological Procedures***	\$	20,294	(20,294)				
	g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$						
	h. Laboratory***	\$	134,129	(134,129)				
	i. Recreation	\$	25,908	25,908				
	j. Direct Management Services*	\$	32,625		32,625			
	k. Indirect Management Services*	\$	29,000		29,000			
	l. Cable TV	\$						
	m. Other (Specify)**** See Attached Schedule	\$	101,681	147,175	(45,494)			
	n. Physical Therapy Expense	\$						
	o. Speech Therapy Expense	\$						
5P.	Total Resident Care Expenditures (5a - 5o)	\$	529,973	1,474,076	(944,103)			

* 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 Montowese Health & Rehabilitation Center			License No. 2442	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
CWPM, LLC	25 Norton Place, Plainville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>		Rubbish Removal	35,550			22	6f
Procure LTC Pharmacy	111 Excutive Blvd Farmingdale NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners: Minority Interest	Pharmacy Services	751,763			20	5A2 &
ADP	PO Box 842875, Boston, MA 02284-2875	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Processing	28,295			16	m13
Executive Landscaping	PO Box 185790, Hamden, CT 06518	<input type="radio"/>	<input checked="" type="radio"/>		Landscaping and Snow Removal Services	52,175			22	6f
		<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
Montowese Health & Rehabilitation Center	2442	9/30/2023					22	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	\$ 124,183	124,183						
b. Heat	\$ 60,032	60,032						
c. Light & Power	\$ 115,525	115,525						
d. Water	\$ 93,623	93,623						
e. Equipment Lease (<i>Provide detail on page 22b</i>)	\$ 18,159	18,159						
f. Other (<i>itemize</i>)	\$ 116,012	116,012						
See Attached Schedule								
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 527,534	527,534						
7. Depreciation (<i>complete schedule page 23*</i>)								
a. Land Improvements	\$							
b. Building & Building Improvements	\$							
c. Non-Movable Equipment	\$							
d. Movable Equipment	\$ 16,471	82,977	(66,506)					
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 16,471	82,977	(66,506)					
8. Amortization (<i>Complete att. Schedule Page 24*</i>)								
a. Organization Expense	\$ 611,745	611,745						
b. Mortgage Expense	\$							
c. Leasehold Improvements	\$ 6,840	6,840						
d. Other (<i>Specify</i>)	\$							
*8e. Total Amortization Costs (8a + b + c + d)	\$ 618,585	618,585						
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 916,063	916,063						
10. Property Taxes								
a. Real estate taxes paid by owner	\$ 196,842	196,842						
b. Real estate taxes paid by lessor	\$							
c. Personal property taxes	\$ 20,376	20,376						
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,768,337	1,834,843	(66,506)					

* 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
Montowese Health & Rehabilitation Center			2442	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, PO Box 371887, Pittsburgh, PA 15250	<input type="radio"/>	<input checked="" type="radio"/>	Mail Machine	01/31/18	63	2,126	1,594	
Xerox, PO Box 202882, Dallas, TX 75320-2882	<input checked="" type="radio"/>	<input type="radio"/>	Copier	12/08/20	36	16,667	16,565	
	<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"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes	<input type="radio"/> No
Total ***							18,159	

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

Depreciation Schedule

Name of Facility Montowese Health & Rehabilitation Center			License No. 2442		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			
A. Land Improvements													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal													
B. Building and Building Improvements													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal													
C. Non-Movable Equipment													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal													
		Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
		Yes	No	Month	Year								
D. Movable Equipment													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a.													
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period					9	2022	817,392	817,392	665,890	SL	Various	80,046	
b. Disposals (attach schedule)													
Acquired during this report period (attach schedule):													
c. Administrative					9	2023	8,587	8,587		SL	Various	859	
d. Standard Resident					9	2023	20,712	20,712		SL	Various	2,072	
e. Specialized Resident													
Total Acquired during this report period							29,299	29,299				2,931	
D-3. Subtotal													82,977
E. Total Depreciation													82,977

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
Additions:					
Jan-23	TV's	Standard Resident	\$ 1,416	5	\$ 142
Jan-23	TV's	Standard Resident	\$ 1,591	5	\$ 159
Jan-23	patient lift	Standard Resident	\$ 2,046	10	\$ 205
Mar-23	Ice Machine	Administrative	\$ 6,636	10	\$ 664
May-23	Bladder Scanner	Standard Resident	\$ 7,431	7	\$ 743
May-23	TV's	Standard Resident	\$ 3,936	5	\$ 394
Jun-23	mattresses	Standard Resident	\$ 2,208	5	\$ 221
Jun-23	beds	Standard Resident	\$ 2,084	5	\$ 208
Aug-23	floor waxer/cleaner	Administrative	\$ 1,951	5	\$ 195
Total additions for Movable Equipment			\$ 29,299		\$ 2,931 *
Deletions:					
Total deletions for Movable Equipment			\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Apr-23	Sprinkler heads	\$ 5,215	25	\$ 104
Sept-23	AC Compressor	\$ 8,551	15	\$ 285
Sept-23	AC Compressor	\$ 8,030	15	268
Sept-23	B&G pump	\$ 12,252	15	408
Total additions for Leasehold Improvement		\$ 34,048		\$ 1,065 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*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
Montowese Health & Rehabilitation Center			2442		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							
A. Organization Expense									
1. Organization Expense	Jan	2018	10 YRS	6,059,160	2,762,936	S/L		611,745	
2.									
3.									
A-4. Subtotal									611,745
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period	9	2022	Various	47,065	2,887	S/L	Var	5,775	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2023	Various	34,048		S/L	Var	1,065	
C-4. Subtotal									6,840
D. Total Amortization									618,585

* 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 Montowese Health & Rehabilitation C	License No. 2442	Report for Year Ended 9/30/2023	Page 25	of 37	
11. Property Questionnaire					
Part A					
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 NOT Original Owner, Date of Purchase					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	120				
6. Square Footage					
7. Acquisition Cost					
a. Land	200,000				
b. Building	9,020,870				
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th 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 _____					
Complete if Mortgage was Refinanced During Current Cost Year					
g. Type of Financing (e.g., fixed, variable)					
h. Date of Refinancing					
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed					
l. Principal Outstanding on Note Paid-Off					
Part C - Arms-Length Leases for Real Property Improvements Only					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	

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

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

Name of Facility		License No.	Report for Year Ended				Page	of
Montowese Health & Rehabilitation C		2442	9/30/2023				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. Total Building Interest Expense (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	
Montowese Health & Rehabilitatio		2442		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)				\$						
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) Vendor Interest = \$63,237				\$	63,237	63,237				
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	63,237	63,237				
14. Insurance										
a. Insurance on Property (buildings only)				\$	97,258	97,258				
b. Insurance on Automobiles				\$						
c. Insurance other than Property (as specified above)										
1. Umbrella (Blanket Coverage)				\$						
2. Fire and Extended Coverage				\$						
3. Other (Specify)				\$						
14d. Total Insurance Expenditures (14a + b + c)				\$	97,258	97,258				
15. Total All Expenditures (A-13 thru C-14)				\$	17,136,575	19,430,548	(2,293,973)			

F. Statement of Revenue

Name of Facility Montowese Health & Rehabilitation Cent 2442		License No.		Report for Year Ended 9/30/2023		Page 30	of 37
Item	Total	CCNH / RHNS	(Specify)	(Specify)			
I. Resident Room, Board & Routine Care Revenue							
1. a. Medicaid Residents (<i>CT only</i>)	\$ 12,717,720	12,717,720					
b. Medicaid Room and Board Contractual Allowance **	\$ (6,119,236)	(6,119,236)					
2. a. Medicaid (<i>All other states</i>)	\$						
b. Other States Room and Board Contractual Allowance **	\$						
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 2,997,578	2,997,578					
b. Medicare Room and Board Contractual Allowance **	\$ 686,759	686,759					
4. a. Private-Pay Residents and Other	\$ 4,968,337	4,968,337					
b. Private-Pay Room and Board Contractual Allowance **	\$ (423,021)	(423,021)					
II. Other Resident Revenue							
1. a. Prescription Drugs - Medicare	\$ 294,299	294,299					
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (294,299)	(294,299)					
c. Prescription Drugs - Non-Medicare	\$ 572,612	572,612					
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (572,612)	(572,612)					
2. a. Medical Supplies - Medicare	\$ 12,779	12,779					
b. Medical Supplies - Medicare Contractual Allowance **	\$ (6,147)	(6,147)					
c. Medical Supplies - Non-Medicare	\$ 1,307	1,307					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (1,307)	(1,307)					
3. a. Physical Therapy - Medicare	\$ 1,557,570	1,557,570					
b. Physical Therapy - Medicare Contractual Allowance **	\$ (1,082,357)	(1,082,357)					
c. Physical Therapy - Non-Medicare	\$ 1,076,450	1,076,450					
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (1,076,450)	(1,076,450)					
4. a. Speech Therapy - Medicare	\$ 294,915	294,915					
b. Speech Therapy - Medicare Contractual Allowance **	\$ (191,451)	(191,451)					
c. Speech Therapy - Non-Medicare	\$ 201,825	201,825					
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (201,825)	(201,825)					
5. a. Occupational Therapy - Medicare	\$ 1,503,517	1,503,517					
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (1,071,072)	(1,071,072)					
c. Occupational Therapy - Non-Medicare	\$ 1,103,250	1,103,250					
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (1,103,250)	(1,103,250)					
6. a. Other (<i>Specify</i>) - Medicare	\$						
b. Other (<i>Specify</i>) - Non-Medicare	\$ 267,837	267,837					
III. Total Resident Revenue (Section I. thru Section II.)	\$ 16,113,728	16,113,728					
IV. Other Revenue*							
1. Meals sold to guests, employees & others	\$						
2. Rental of rooms to non-residents	\$						
3. Telephone	\$						
4. Rental of Television and Cable Services	\$						
5. Interest Income (<i>Specify</i>)	\$ 180,090	180,090					
6. Private Duty Nurses' Fees	\$						
7. Barber, Coffee, Beauty and Gift shops	\$						
8. Other (<i>Specify</i>)	\$ 39,096	39,096					
V. Total Other Revenue (1 thru 8)	\$ 219,186	219,186					
VI. Total All Revenue (III +V)	\$ 16,332,914	16,332,914					

* 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)
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
	Retroactives	\$ 247,000		
	Retroactives	\$ 20,837		
Total Other Resident Revenue		\$ 267,837	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	(Specify)
30/IV5	Interest on A/R		\$ 935		
30/IV5	Interest ERC		\$ 180,684		
30/IV5	Interest Income on Accounts Rec		\$ (1,529)		
Total Interest Income			\$ 180,090	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
	Bad Debt Recovery	\$ 39,096		
Total Other Revenue		\$ 39,096	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Ce	2442	9/30/2023	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	82,629
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,927,527
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	26,555
5. Prepaid Expenses			\$	275,171
a. Prepaid Insurance	126,193			
b. Prepaid health insurance	24,300			
c. Prepaid Tax	114,868			
d. See Schedule	9,810			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	2,311,882
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>81,113</u>		\$	71,386
	Accum. Depreciation <u>9,727</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>545,415</u>		\$	(203,452)
	Accum. Depreciation <u>748,867</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	317,444
Moveable Equipment Carryforward	301,277			
See Schedule	16,167			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	185,378

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
		Prepaid Expense	\$ 9,810
		Total Prepaid Expenses	\$ 9,810

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

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

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

Page Ref	Line Ref	Description	
		Project Development	\$ 16,167
		Total Other Other Fixed Assets (Itemize)	\$ 16,167

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Deposits-Taxes	\$ 129,723
		Total Other Assets	\$ 129,723

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
Montowese Health & Rehabilitation Ce	2442	9/30/2023	32	37
Account			Amount	
Total Brought Forward:			\$	2,497,260
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Non-Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
5. Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
6. Motor Vehicles				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense				
	*Historical Cost	6,059,160		
	Accum. Depreciation	3,374,681	Net	\$ 2,684,479
4. Goodwill (Purchased Only)			\$	(7,605)
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>)			\$	392,854
	Deposits-Lease & Security Deposit	227,311		
	Start Up Costs	35,820		
	See Schedule	129,723		
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	3,069,728
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	5,566,988

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

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Center		2442	9/30/2023	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	3,127,370
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>)				\$	601,218
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	253,480
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>)				\$	1,896,652
Acc'd Operating Expenses		65,873			
Acc'd Expense - Sales Tax		(96)			
Provider Taxes Due		1,830,875			
See Schedule					
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	5,878,720

* 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 Montowese Health & Rehabilitation Center	License No. 2442	Report for Year Ended 9/30/2023		Page 34	of 37
Account				Amount	
Total Brought Forward:				5,878,720	
Liabilities (cont'd)					
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>)				\$ 7,565,743	
Name and Address of Lender	Amount	Loan Date			
Intercompany	6,852,850				
N/P short term + Notes Pay-Procure Investment	712,893				
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ 238,603	
Notes Payable-Procure CT		238,603			
See Schedule					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 7,804,346	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 13,683,066	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation C	2442	9/30/2023	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<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. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	3,375,000
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(8,394,973)
6. Gain or Loss for Period			\$	(3,096,105)
	10/1/2022	thru	9/30/2023	
7. Total Net Worth			\$	(8,116,078)
C. Total Reserves and Net Worth			\$	(8,116,078)
D. Total Liabilities, Reserves, and Net Worth			\$	5,566,988

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Montowese Health & Rehabilitation Cen	2442	9/30/2023	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2022			\$	(8,324,883)
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	16,334,443
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	19,430,548
D. Net Income or Deficit			\$	(3,096,105)
E. Balance			\$	(11,420,988)
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
ERC	3,523,816	(218,906)		
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	3,304,910
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. Balance at End of Period			\$	(8,116,078)
				09/30/23

I. Preparer's/Reviewer's Certification

Name of Facility Montowese Health & Rehabilitation	License No. 2442	Report for Year Ended 9/30/2023	Page 37	of 37
<i>Check appropriate category</i>				
<input type="checkbox"/> Chronic and Convalescent Nursing <input type="checkbox"/> Home (CCNH) & RHNS <input type="checkbox"/> Combined	<input type="checkbox"/> (Specify)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<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 Associates, Inc				
Address Address		Phone Number		
135 South Road 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				