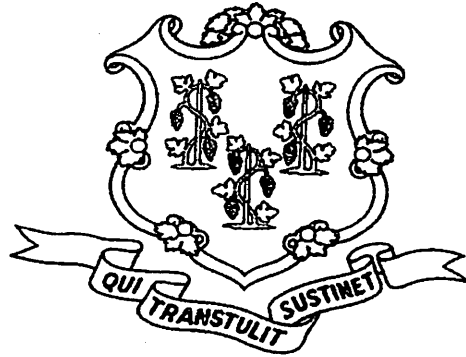


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2021

Name of Facility (as licensed) FILOSA FOR NURSING AND REHABILITATION	
Address (No. & Street, City, State, Zip Code) 13 HAKIM STREET	
Type of Facility Chronic and Convalescent Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only <input type="checkbox"/> Supervision only <input type="checkbox"/> (Specify) (CCNH) (RHNS)	
Report for Year Beginning 10/10/2020	Report for Year Ending 9/30/2021

License Numbers:	CCNH 461-C	RHNS	(Specify)	Medicare Provider 07-5074
------------------	---------------	------	-----------	------------------------------

Medicaid Provider Numbers:	CCNH 4614	RHNS	ICF-IID
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For Department Use Only

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

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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 FILOSA FOR NURSING AND REHABILITATION	Period Covered:	From #####	To 9/30/2021	
Address of Facility 13 HAKIM STREET				
Report Prepared By	Phone Number	Date		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2021	1	37

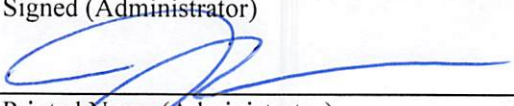
Administrator's/Owner's Certification

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 FILOSA FOR NURSING AND REHABILITATION [facility name], for the cost report period beginning October 10, 2020 and ending September 30, 2021, 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
		2/15/22			2/15/22
Printed Name (Administrator)			Printed Name (Owner)		
JENNIFER MALONE-SEIXAS			BARBARA A. MALONE		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires	
				/ /	
Address of Notary Public					

(Notary Seal)

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-794-9466		Report for Year Ended 9/30/2021	Page 2	of 37
Name of Facility (as shown on license) FILOSA FOR NURSING AND REHABILITATION		Address (No. & Street, City, State, Zip) 13 HAKIM STREET		
License Numbers:	CCNH 461-C	RHNS	(Specify)	Medicare Provider No. 07-5074
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" 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 JENNIFER MALONE-SEIXAS		Nursing Home Administrator's License No.:	00-1928	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

General Information and Questionnaire
Corporate Owners

Name of Facility FILOSA FOR NURSING AND REHABILIT	License No. 461-C	Report for Year Ended 9/30/2021	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address	State(s) in Which Incorporated		
FILOSA CONVALESCENT HOME, INC	13 HAKIM STREET, DANBURY, CT 06810	CONNECTIC UT		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
FRANK D. MALONE	105 MIDDLE RIVER ROAD, DANBURY, CT 06811	TREASURER	122	
BARBARA A. MALONE	105 MIDDLE RIVER ROAD, DANBURY, CT 06811	SECRETARY	491	
JENNIFER MALONE-SEIXAS	592 MANVILLE ROAD, PLEASANTVILLE, NY 10570	PRESIDENT	125	
MICHAEL D. MALONE	197 GUINEA ROAD, MONROE, CT 06468	VICE-PRESIDENT	129	
JOHN M. MALONE	22 NORTH DUTCHER STREET, IRVINGTON, NY 10533	DIRECTOR	119	
Names of Stockholders Owning at Least 10% of Shares				
FRANK D. MALONE	105 MIDDLE RIVER ROAD, DANBURY, CT 06811	TREASURER	122	
BARBARA A. MALONE	105 MIDDLE RIVER ROAD, DANBURY, CT 06811	SECRETARY	491	
JENNIFER MALONE-SEIXAS	592 MANVILLE ROAD, PLEASANTVILLE, NY 10570	PRESIDENT	125	
MICHAEL D. MALONE	197 GUINEA ROAD, MONROE, CT 06468	VICE-PRESIDENT	129	
JOHN M. MALONE	22 NORTH DUTCHER STREET, IRVINGTON, NY 10533	DIRECTOR	119	

**General Information and Questionnaire
 Related Parties***

Name of Facility FILOSA FOR NURSING AND REHABILITATION	License No. 461-C	Report for Year Ended 9/30/2021	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	%**				
FILOSA CARE CENTER DBA HANCOCK HALL	31 STAPLES ST., DANBURY, CT 06811	<input type="radio"/>	<input checked="" type="radio"/>		SHARED EXPENSES	SEE ATTACHED	SEE ATTACHED	SEE ATTACHED
BARBARA A. MALONE (BAMCO, LLC)	105 MIDDLE RIVER ROAD, DANBURY, CT 06811	<input type="radio"/>	<input checked="" type="radio"/>		BUILDING RENTAL/DEPRECIATION/RE	22/9 22/7b	780,000	780,000
SPACE PANTS, LLC	197 GUINEA ROAD, MONROE, CT 06468	<input type="radio"/>	<input checked="" type="radio"/>		PARKING LOT RENTAL	22/9	8,100	6,480
MICHAEL MALONE	197 GUINEA ROAD, MONROE, CT 06468	<input type="radio"/>	<input checked="" type="radio"/>		ADMINISTRATOR/OFFICER/CORP COUN	10/A1/A2	126,355	126,355
FILOSA CARE CENTER DBA HANCOCK HALL	31 STAPLES ST., DANBURY, CT 06811	<input type="radio"/>	<input checked="" type="radio"/>		ADVANCED FUNDS	34/B3	71,198	71,198
SPACE PANTS, LLC	197 GUINEA ROAD, MONROE, CT 06468	<input type="radio"/>	<input checked="" type="radio"/>		OFF SITE STORAGE	22/9	6,480	6,480
		<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 FILOSA FOR NURSING AND REHABILITA	License No. 461-C	Report for Year Ended 9/30/2021	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.

SEE ATTACHED

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.

**FILOSA FOR NURSING AND REHABILITATION
COST YEAR 2021
LICENSE NO 481-C**

ATTACHMENT TO PAGE 4 OF 37 GENERAL INFORMATION AND QUESTIONAIRE

Name of Related Individual or Company	Description of Goods / Services Provided	Costs are Included in Annual Report Page# / Line#	FCH Portion	HH Portion
HANCOCK HALL 31 STAPLES STREET, DANBURY, CT 06810	THE FACILITY SHARES A NON-DISCRIMINATORY PENSION PLAN, WITH HANCOCK HALL. WITH EACH FACILITY PAYING THEIR SHARE	Actual 15.1.A.8.D	\$11,757	\$33,764
	401K FINANCIAL STATEMENT AUDIT	* 15.1.A.9.D	\$0	\$0
HANCOCK HALL 31 STAPLES STREET, DANBURY, CT 06810	INSURANCE IN CONJUNCTION WITH HANCOCK HALL VARIOUS INSURANCES			
	WORKMENS COMPENSATION	* 15.1.A.1	\$74,755	\$110,177
	DISABILITY	Actual 15.1A.2	\$3,095	\$18,682
	HEALTH AND DENTAL	Actual 15.1.A.5	\$297,103	\$372,575
	PROPERTY: INSURANCE ON PROPERTY	* 27.14.A	\$1,337	\$2,006
	INSURANCE OF AUTOMOBILES	Actual * 27.14.B	\$2,871	\$5,410
	UMBRELLA	* 27.14.C.1	\$10,920	\$16,380
	FIRE AND EXTENDED COVERAGE	Actual * 27.14.C.2	\$45,910	\$81,090
	FIDUCIARY	Actual * 27.14.C.3	\$188	\$22,009
	DIRECTORS AND OFFICER	* 27.14.C.3	\$14,873	\$1,175
	CYBER LIABILITY	* 27.14.C.3	\$2,004	\$3,006
TOTAL PROPERTY INS			\$77,902	\$131,076
BOTH HANCOCK HALL & FILOSA CONVALESCENT HOME, SHARE THE WAGES OF THESES EMPLOYEES				
HANCOCK HALL 31 STAPLES STREET, DANBURY, CT 06810	SHARED EMPLOYEE WAGES:			
	HEAD ACCOUNTANT'S (1)	* 10.11.A	\$51,481	\$77,222
	OTHER ACCOUNTANTS (5)	* 10.A6.B	\$74,938	\$154,378
	HEAD HOUSEKEEPER (1)	** 10.A.6.A	\$35,340	\$50,855
	ENGINEER OR CHIEF OF MAINTENANCE (1)	*** 10.A.7.A	\$46,218	\$66,506
	FOOD SERVICE SUPERVISOR (1)	* 10.A6.B	\$32,855	\$49,282
	RN - ADMINISTRATIVE (1)	Actual 10.A.12.B.2	\$0	\$0
	LPN - ADMINISTRATIVE (1)	Actual 10.A.12.C.2	\$0	\$0
	OTHER ADMINISTRATIVE SALARIES (1)	* 10.A.4	\$59,190	\$96,862
	RECREATION DIRECTOR	* 10.A.12.H	\$20,013	\$30,019
	RECREATION WORKERS	Actual 10.A.12.H	\$91,834	\$84,844
TOTAL WAGES			\$411,887	\$609,988
HANCOCK HALL 31 STAPLES STREET, DANBURY, CT 06810	VEHICLE EXPENSES-BOTH HANCOCK HALL & FILOSA CONVALESCENT HOME SHARE, USE OF THE COMPANY UTILITY TRUCK & VAN.			
	EXPENSES FOR VAN ON HANCOCK AND EXPENSES FOR TRUCK ON FILOSA	Actual 16.L.7	\$3,951	\$1,128
HANCOCK HALL 31 STAPLES STREET, DANBURY, CT 06810	TELEPHONE AND INTERNET	* 15.1H1	\$15,914	\$19,524
	TELEPHONE SYSTEM INTEREST	* 22.7.D	\$435	\$657

* Allocated according to the facilities ratio of its beds to 160- the combined total of bot Hancock Hall and Filosa. Under this method of allocation Hancock is charged 60% (96/160) of expense while Filosa is charged 40% (64/160).

** Allocated according to the facilities rationof it's square footage to 95,905 square feet. - the combined square footage of both Hancock Hall & Filosa. Under this method of allocation Hancock Hall is charged 59% (56,300/95,905) of expense while Filosa is charged 41% (39,605/95,905)

*** Allocated as follows: Billing and Census 80% Hancock Hall 20% Filosa. Accounting 60% Hancock Hall 40% Filosa

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	
FILOSA FOR NURSING AND REHABILITATION		461-C	9/30/2021			6	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						
WELLS FARGO/RICOH USA , PO BOX 41554, PHILADELPHIA, PA 19101	<input type="radio"/>	<input checked="" type="radio"/>	COPIER MACHINE LEASE	08/01/18	60 MONTH LEASE	8,161	8,161	
	<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"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?						<input type="radio"/> Yes	<input checked="" type="radio"/> No	Total ***
							8,161	

* 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.

**General Information and Questionnaire
 Accounting Basis**

Name of Facility FILOSA FOR NURSING AND RE	License No. 461-C	Report for Year Ended 9/30/2021	Page 7	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 CLIFTON LARSON ALLEN, LLP	300 CROWN COLONY DRIVE, STE 310, QUINCY MA 02169
2 CLIFTON LARSON ALLEN, LLP	300 CROWN COLONY DRIVE, STE 310, QUINCY MA 02169
3	
4	

Services Provided by This Firm (*describe fully*)

1	COMPILATION FINANCIAL STATEMENT	\$	8,705
2	COVID CONSULTING	\$	1,227
3		\$	
4		\$	
			Charge for Services Provided
			\$ 9,932

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No 15 1D, 16 M13

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 MICHALIK, BAUER, SILVIA & CICCARILO, LLP	860-225-8403
2 MURTHA & CULLINA, LP	203-772-7728
3	
4	
5	

Address (*No. & Street, City, State, Zip Code*)
 1 35 PEARL STREET, SUITE 300, NEW BRITAIN, CT, 06051-2645
 2 265 CHURCH STREET, NEW HAVEN CT 06510
 3
 4
 5

Services Provided by This Firm (*describe fully*)

1	COLLECTION SERVICES	\$	15,166
2	CONSULTING	\$	3,105
3		\$	
4		\$	
5		\$	
			Charge for Services Provided
			\$ 18,271

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No 15 1E, 16 M13

Schedule of Resident Statistics

Name of Facility FILOSA FOR NURSING AND REHABILITATION			License No. 461-C		Report for Year Ended 9/30/2021				Page 8	of 37			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	64	64			64	64							
B. On last day of THIS report period	64	64							64	64			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	55	55			55	55							
B. As of midnight of THIS report period	48	48							48	48			
3. Total Number of Days Care Provided During Period													
A. Medicare	2,066	2,066			1,460	1,460			606	606			
B. Medicaid (Conn.)	12,659	12,659			9,617	9,617			3,042	3,042			
C. Medicaid (other states)													
D. Private Pay	3,089	3,089			2,592	2,592			497	497			
E. State SSI for RCH													
F. Other (Specify) MEDICARE ADVANTAGE	295	295			189	189			106	106			
G. Total Care Days During Period (3A thru F)	18,109	18,109			13,858	13,858			4,251	4,251			
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	1	1			1	1							
5. Total Resident Days (3G + 4A + 4B)	18,110	18,110			13,859	13,859			4,251	4,251			

Schedule of Resident Statistics (Cont'd)

Name of Facility FILOSA FOR NURSING AND REHABILITATION			License No. 461-C			Report for Year Ended 9/30/2021			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 (1)	RHNS (2)	(Specify) (3)	Lost			Gained			CCNH	RHNS	(Specify)	
				(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days										CCNH	RHNS	(Specify)	
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid			Self-Pay			Other State Assisted				
	CCNH		CCNH	RHNS		CCNH	RHNS	(Specify)	R.C.H.	ICF-MR			
No. of Residents	6		32			10							
Per Diem Rate													
a. One bed rm.						517.00							
b. Two bed rms.	700.00		305.98			490.00							
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments										TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B										4,253	4,253		
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other										5,078	5,078		
D. Total Physical Therapy Treatments										9,331	9,331		
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B										286	286		
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other										349	349		
D. Total Speech Therapy Treatments										635	635		
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B										3,831	3,831		
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other										5,457	5,457		
D. Total Occupational Therapy Treatments										9,288	9,288		

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2021	10	37		
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes <input type="radio"/> No				
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)	59,269					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	96,768	2,324				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	142,395	5,640				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	32,855	806				
c. Dietary Workers	368,505	19,272				
6. Housekeeping Service						
a. Head Housekeeper	35,340	853				
b. Other Housekeeping Workers	224,295	14,825				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	46,216	853				
b. Other Maintenance Workers	99,742	3,711				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	60,685	3,584				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant	51,481	832				
b. Other Accountants	74,938	2,588				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	107,962	2,080				
b. RN						
1. Direct Care	665,376	18,177				
2. Administrative**	131,432	3,196				
c. LPN						
1. Direct Care	531,874	18,452				
2. Administrative**	342	11				
d. Aides and Attendants	1,065,974	57,097				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	111,848	4,718				
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	69,822	1,772				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	57,169	311				
A-13. Total Salary Expenditures	4,034,287	161,100				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
COVID RELATED INCENTIVE WAGES AND BONUSES	\$ 57,169	311				
Total	\$ 57,169	311	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

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

**FILOSA FOR NURSING AND REHABILITATION
COST YEAR 2021
LICENSE NO 461-C**

ATTACHMENT TO PAGE 11C OF 37 GENERAL INFORMATION AND QUESTIONNAIRE

OWNER SALARY

	HANCOCK		FILOSA		COMBINED TOTAL		FICA	
	HRS	SALARY	HRS	SALARY	HRS	SALARY	ALLOW	DISALLOW
JENNIFER MALONE-SEIXAS ADMINISTRATOR PRESIDENT	2,080	93,725	-	-	2,080	93,725	-	-
	-	97,524	-	-	-	97,524	-	-
	2,080	\$ 191,249	-	\$ -	2,080	\$ 191,249		
MICHAEL MALONE ADMINISTRATOR CORPORATION COUNSEL VICE-PRESIDENT	-	-	1,570	60,493	1,570	60,493	6,159	6,195
	-	646	-	6,593	-	7,239		
	-	28,332	-	59,269	-	87,601		
	-	28,978	2,080	\$ 126,355	1,570	\$ 155,333	\$ 6,159	\$ 6,195

ADMINISTRATOR ALLOWANCE

	Total	MAXIMUM ALLOWABLE				Excess	Amount Allowed Total	
		@60 Beds	Per Bed	#Beds	Beds 96		Beds 96	
MICHAEL MALONE	\$ 60,493	\$ 78,949	390	4	\$ 1,560	\$ 80,509	\$ 16,259	Disallow
STEPHANIE VITKO-ANIOLEK	\$ 36,275							

**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	
FILOSA FOR NURSING AND REHABILITATION				461-C	9/30/2021			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)							
Section I - Operators/Owners										
JENNIFER MALONE-SEIXAS				SAMES AS OTHER EMPLOYEES	PRESIDENT/ADMINISTRATOR			HANCOCK HALL 31 STAPLES ST DANBURY CT	2,080	191,249
MICHAEL MALONE	59,269			SAMES AS OTHER EMPLOYEES	VICE-PRESIDENT/CORP COUNSEL		A1	HANCOCK HALL 31 STAPLES ST DANBURY CT		28,332
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).										
MICHAEL MALONE	6,593				CORPORATION COUNSEL		A4	HANCOCK HALL 31 STAPLES ST DANBURY CT		646

* 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		
FILOSA FOR NURSING AND REHABILITATION			461-C	9/30/2021			12	37		
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
MICHAEL MALONE	60,493					1,570	A2			
STEPHANIE VITKO-ANIOLEK	36,275			SAMES AS OTHER EMPLOYEES		754				
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.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
FILOSA FOR NURSING AND REHABILITATIO	461-C	9/30/2021	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian	26,213	583				
2. Dentist	6,090					
3. Pharmacist	7,148	101				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	185,089	2,893				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	21,500	121				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)	720	4				
2. Pharmaceutical Committee (Quarterly meetings)	720	4				
3. Staff Development Committee (Once annually)	360	2				
e. Other (Specify) PSYCHIATRIC EVALUATIONS	8,600	51				
9. Speech Therapist						
a. Resident Care	55,945	550				
b. Other						
10. Occupational Therapist						
a. Resident Care	178,520	2,344				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	490,904	6,652				

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

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

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

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

Name of Facility FILOSA FOR NURSING AND REHABILITATION		License No. 461-C		Report for Year Ended 9/30/2021	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
SERAFIMA GLOUZGAL,MD, 388 GROVE ST, RIDGEFIELD, CT 06877	COORDINATION OF MEDICAL CARE FOR RESIDENTS	<input type="radio"/>	<input checked="" type="radio"/>			
HEALTH DRIVE DENTAL GROUP, 888 WORCHESTER ST, WELLESLEY, MA	EVALUATION AND DENTAL GROUP	<input type="radio"/>	<input checked="" type="radio"/>			
SYMBRIA REHAB, 28100 TORCH PARKWAY, WARRENVILLE, IL 60555	PT, OT AND SPEECH EVALUATIONS AND TREATMENT	<input type="radio"/>	<input checked="" type="radio"/>			
ORESTES ARCUNI, MD , 4 BARTRAM DRIVE, WEST REDDING, CT 06896	PSYCHIATRIC EVALUATIONS AND SERVICES	<input type="radio"/>	<input checked="" type="radio"/>			
REV. DAVID FRANKLIN, ST. JOSEPH'S ROMAN CATHOLIC CHURCH, 8 ROBINSON	MASS AND CLERGY VISITS TO FACILITY RESIDENTS	<input type="radio"/>	<input checked="" type="radio"/>			
OMNICARE PHARMACY, 525 KNOTTER DRIVE, CHESHIRE, CT	INFECTION CONTROL REVIEW, PHARMACEUTICAL REVIEW,	<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"/>			
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		<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
FILOSA FOR NURSING AND REHABILITAT	461-C	9/30/2021	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 74,755	74,755		
2. Disability Insurance	\$ 3,095	3,095		
3. Unemployment Insurance	\$ 38,696	38,696		
4. Social Security (F.I.C.A.)	\$ 299,756	299,756		
5. Health Insurance	\$ 297,103	297,103		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 11,757	11,757		
8. Uniform Allowance	\$ 2,848	2,848		
9. Other (<i>Specify</i>) See Attached Schedule	\$ 5,844	5,844		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 24,000	24,000		
d. Accounting and Auditing	\$ 8,705	8,705		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 17,086	17,086		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 26,861	26,861		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 9,439	9,439		
2. Cellular Phones	\$ 1,205	1,205		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 4,446	4,446		
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$ (49,400)	(49,400)		
2. Other (<i>Specify</i>) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 331,065	331,065		
Subtotal	\$ 1,107,261	1,107,261		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
PHYSICALS	\$ 5,844		
Total	\$ 5,844	\$ -	\$ -

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2021	16	37
Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	1,107,261	1,107,261		
1. Travel and Entertainment				
1. Resident Travel and Entertainment	\$ 600	600		
2. Holiday Parties for Staff	\$ 1,376	1,376		
3. Gifts to Staff and Residents	\$ 8,942	8,942		
4. Employee Travel	\$			
5. Education Expenses Related to Seminars and Conventions	\$ 1,503	1,503		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 3,951	3,951		
7. Other (<i>Specify</i>) See Attached Schedule	\$			
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 22,412	22,412		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$			
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 18,899	18,899		
4. Fund-Raising***	\$			
5. Medical Records	\$ 6,307	6,307		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$			
7. Postage	\$ 1,777	1,777		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 6,003	6,003		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$ 619	619		
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>)	\$ 7,453	7,453		
12. Administrative Management Services**	\$			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 164,893	164,893		
C-14 Total Administrative & General Expenditures	\$ 1,351,996	1,351,996		

* Do not include Subscriptions, which should go in item 9.

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
PROMOTIONS	\$ 18,899		
Total Other Advertising	\$ 18,899	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
AANAC	\$ 131		
AHCA	\$ 640		
ACHCA	\$ 620		
CAHCF	\$ 4,532		
CATRD	\$ 80		
Total Dues	\$ 6,003	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
EQUIPMENT RENTAL ADMIN	\$ 2,422		
SMALL EQUIPMENT ADMINISTRATION	\$ 999		
MAINT SUPPLIES - SMALL EQUIP	\$ 1,742		
CABLE TV EXPENSE	\$ 15,305		
OFFICE EXPENSE - INTERNET	\$ 6,475		
OFFICE EXPENSE - SOFTWARE	\$ 43,908		
COMPUTER EXPENSE - HOSTING	\$ 8,431		
COMPUTER EXPENSE - SERVICE	\$ 9,159		
PAYROLL SERVICE	\$ 11,730		
MISCELLANEOUS EXPENSE	\$ 1,891		
PROFESSIONAL DUES/LICENSE/FEEs	\$ 2,934		
BANK SERVICE CHARGES	\$ 3,080		
RESIDENT RELATED MISC EXP	\$ 1,000		
OTHER COVID RELATED COST	\$ 55,817		
Total Other Administrative and General	\$ 164,893	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility FILOSA FOR NURSING AND REHABI	License No. 461-C	Report for Year Ended 9/30/2021	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #

*** 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
FILOSA FOR NURSING AND REHABILITATION		461-C	9/30/2021		18	37
Item		Total	CCNH	RHNS	(Specify)	
2. Dietary						
a. In-House Preparation & Service						
1.	Raw Food	\$ 141,924	141,924			
2.	Non-Food Supplies	\$ 23,321	23,321			
3.	Other (Specify) _____	\$ _____				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)						
c. Other (Specify) _____						
DIETARY EQUIPMENT RENTAL		\$ 1,110	1,110			
2D. Total Dietary Expenditures (2a + b + c + d)		\$ 166,355	166,355			
2E. Dietary Questionnaire						
F.	Resident Meals: Total no. of meals served per day:*	149	149			
G.	Is cost of employee meals included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No			
H.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K.	Is any revenue collected from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
N.	Is any revenue collected from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)						

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2021	19	37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	9,122	9,122	
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. \$	11,633	11,633	
b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	\$			
c. Other (<i>Specify</i>) EQUIPMENT RENTAL	\$	8,295	8,295	
3D. Total Laundry Expenditures (3a + b + c)	\$	29,050	29,050	
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
FILOSA FOR NURSING AND REHABILITA		461-C	9/30/2021		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced	39,605	39,605		
a.	In-House Care	by Personnel				
1.	Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	29,406	29,406		
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>) COVID RELATED CLEANING SUPPLIES		\$ 6,880	6,880		
4D.	Total Housekeeping Expenditures (4a + b + c)		\$ 36,286	36,286		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from OMNICARE	\$	53,650	53,650		
b.	Medicine Cabinet Drugs	\$	1,065	1,065		
c.	Medical and Therapeutic Supplies	\$	113,702	113,702		
d.	Ambulance/Limousine***	\$				
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	4,472	4,472		
f.	X-rays and Related Radiological Procedures***	\$	2,600	2,600		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	2,009	2,009		
i.	Recreation	\$	3,474	3,474		
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	61,089	61,089		
5M.	Total Resident Care Expenditures (5a - 5j)	\$	242,061	242,061		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
SMALL EQUIPMENT NURSING	\$ 2,433		
MAINT SUPPLY - RESIDENT AID	\$ 5,897		
PPE RELATED NURSING SUPPLIES	\$ 52,759		
Total Other Resident Care	\$ 61,089	\$ -	\$ -

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

Name of Facility FILOSA FOR NURSING AND REHABILITATION			License No. 461-C		Report for Year Ended 9/30/2021			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)	Pg	Line
ORESTES J. ARCUNI	WEST REDDING, CT 06896	<input type="radio"/>	<input checked="" type="radio"/>		EVALUATIONS AND SERVICES	8,600			13	B8DE
LAURIE A FIGLIOLA RDN	ROAD, WESTON, CT 06883	<input type="radio"/>	<input checked="" type="radio"/>		NEEDS AND REPORTS	26,213			13	B1
SYMBRIA REHAB	PARKWAY, WARRENVILLE, IL	<input type="radio"/>	<input checked="" type="radio"/>		EVALUATIONS AND TREATMENT	419,554			13	Vario
SERAFIMA M. GLOUZGAL	RIDGEFIELD, CT 06877	<input type="radio"/>	<input checked="" type="radio"/>		MEDICAL DIRECTOR	11,500			13	B8A
CENTER FOR COMPREHENSIVE CARE, LLC	580 LONG HILL AVE, SHELTON, CT 06474	<input type="radio"/>	<input checked="" type="radio"/>		MEDICAL DIRECTOR	10,000			13	B8A
CLIFTON LARSON ALLEN LLP	DRIVE, STE 310, QUINCY MA 02169	<input type="radio"/>	<input checked="" type="radio"/>		ACCOUNTING SERVICES	9,932			15 16	1D, N
MICHALIK, BAUER, SILVIA & CICCARILO, LLP	SUITE 300, NEW BRITAIN, CT, 06051	<input type="radio"/>	<input checked="" type="radio"/>		LEGAL SERVICES	15,166			15	1E
FJC AND ASSOCIATES, INC	14 CHURCH HILL RD, NEWTOWN, CT 06470	<input type="radio"/>	<input checked="" type="radio"/>		PENSION CONSULTANT	3,106			15	M11
FLYNN BARRETT CONSULTING LLC	ROAD, POUND RIDGE, NY 10576	<input type="radio"/>	<input checked="" type="radio"/>		HR CONSULTANT	2,653			15, 16	M11
ONMICARE	DETROIT, MI 48278-1668	<input type="radio"/>	<input checked="" type="radio"/>		PHARMACIST	7,148			13	B3
		<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
FILOSA FOR NURSING AND REHABILITATION	461-C	9/30/2021		22	37
Item	Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 79,424	79,424			
b. Heat	\$ 36,790	36,790			
c. Light & Power	\$ 58,902	58,902			
d. Water	\$ 21,339	21,339			
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 8,161	8,161			
f. Other (<i>itemize</i>)	\$ 38,942	38,942			
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 243,558	243,558			
7. Depreciation (<i>complete schedule page 23*</i>)					
a. Land Improvements	\$				
b. Building & Building Improvements	\$ 120,877	120,877			
c. Non-Movable Equipment	\$ 7,168	7,168			
d. Movable Equipment	\$ 38,194	38,194			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 166,239	166,239			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)					
a. Organization Expense	\$				
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$ 45,253	45,253			
d. Other (<i>Specify</i>)	\$				
*8e. Total Amortization Costs (8a + b + c + d)	\$ 45,253	45,253			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 617,275	617,275			
10. Property Taxes					
a. Real estate taxes paid by owner	\$ 56,428	56,428			
b. Real estate taxes paid by lessor	\$				
c. Personal property taxes	\$ 10,575	10,575			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 895,770	895,770			

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

**FILOSA FOR NURSING AND REHABILITATION
COST YEAR 2021
LICENSE NO 461-C**

ATTACHMENT TO PAGE 22 OF 37 - LINE 9 RENTAL PAYMENTS ON LEASED REAL PROPERTY LESS DEPRECIATION CLAIMED

	<u>TOTAL</u>	<u>CCNH</u>	<u>RHNS</u>
RENTAL PAYMENT OF FACILITY BUILDING	\$ 780,000	\$ 780,000	\$ -
LESS: DEPRECIATION ON PROPERTY FROM RELATED PARTY (Does not include depreciation on addition)	<u>(120,877)</u>	<u>(120,877)</u>	<u>-</u>
	\$ 659,123	\$ 659,123	-
 OTHER RENTAL PAYMENTS			
PARKING LOT RENTAL - SPACE PANTS, LLC	8,100	8,100	
RENT OF OFF SITE STORAGE - SPACE PANTS, LLC	<u>6,480</u>	<u>6,480</u>	<u>-</u>
	\$ 673,703	\$ 673,703	\$ -
Real Estate taxes paid by lessor, with funds included as Rent	<u>(56,428)</u>	<u>(56,428)</u>	<u>-</u>
	\$ 617,275	\$ 617,275	-

Depreciation Schedule

Name of Facility FILOSA FOR NURSING AND REHABILITATION			License No. 461-C			Report for Year Ended 9/30/2021			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	4,835,483		4,835,483	3,286,350	SL	40	120,877							
2. Disposals (attach schedule)														
3. Acquired during this report period (attach schedule)														
B-4. Subtotal								120,877						
C. Non-Movable Equipment														
1. Acquired prior to this report period	127,283		127,283	15,434	SL	VARIOUS	7,028							
2. Disposals (attach schedule)														
3. Acquired during this report period (attach schedule)	33,468		33,468				140							
C-4. Subtotal								7,168						
	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. 2015 FORD F250 PICKUP														
	X		10	2015	44,463		44,463	44,463	SL	5				
b.														
c.														
d.														
2. Movable Equipment														
a. Acquired prior to this report period														
					619,044		619,044	424,820			37,374			
b. Disposals (attach schedule)														
					(13,169)		(13,169)	(13,169)						
c. Acquired during this report period (attach schedule)														
					14,619		14,619				820			
D-3. Subtotal														38,194
E. Total Depreciation														166,239

Schedule of Land Improvements Acquired during this report period

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

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

Schedule of Building Improvements Acquired during this report period

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

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

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
8/26/2021	ELEVATOR DOOR UPGRADE AND REPAIR	\$ 33,468	20	\$ 140
Total additions for Non-Movable Equipment		\$ 33,468		\$ 140 *
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ - **

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
4/1/2021	13 OUTDOOR DINING SET	\$ 2,168	10	\$ 90
6/8/2021	HOTPLATE (6)	\$ 4,246	5	\$ 212
1/5/1900	IPAD WI-FI	\$ 2,293	5	\$ 38
5/20/2021	L SHAPE DESK	\$ 1,675	10	\$ 56
3/25/2021	NOTEBOOK 5502	\$ 4,237	5	\$ 424
Total additions for Movable Equipment		\$ 14,619		\$ 820 *
Deletions:				
11/30/2002	ON SITE SETUP OF 2 NEW COMPUTERS	\$ (693)		\$ -
11/5/2014	VIEWSONIC PJD5352 MONITORS	\$ (743)		\$ -
10/1/2014	REBUILD WEBSITE FINAL PHASE	\$ (1,613)		\$ -
5/27/2014	REBUILD WEBSITE PHASE 2	\$ (1,613)		\$ -
3/11/2011	GERIMENU SOFTWARE	\$ (8,507)		\$ -
Total deletions for Movable Equipment		\$ (13,169)		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
5/1/2021	MOTORIZED RETRACTABLE ECLIPSE BRAN	\$ 6,509	10	\$ 217
2/8/2021	REFRIGERATION EQUIPMENT	\$ 5,803	10	\$ 339
Total additions for Leasehold Improvement		\$ 12,312		\$ 555 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility FILOSA FOR NURSING AND REHABILITATION			License No. 461-C		Report for Year Ended 9/30/2021			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period			VARIOUS	855,738	572,339	855,738	VARI	44,698	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)			VARIOUS	12,312		12,312	VARI	555	
C-4. Subtotal									45,253
D. Total Amortization									45,253

* 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) - Interest

Name of Facility		License No.	Report for Year Ended		Page	of
FILOSA FOR NURSING AND REH		461-C	9/30/2021		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
FILOSA FOR NURSING AND R		461-C		9/30/2021		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$ 986	986		
A. Item		Rate	Amount				
ENERGY EFFICIENT LIGHT		4.75%	551				
Lender							
EVERSOURCE							
Address of Lender							
PO BOX 650032DALLAS, TX, 75265-0032							
B. Item		Rate	Amount				
TELEPHONE SYSTEM		5.00%	435				
Lender							
CAROUSEL INDUSTRIES							
Address of Lender							
PO BOX 790488ST LOUIS, MO 63179							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$ 986	986		
12. D. Other Interest Expense (Specify)				\$ 5	5		
VENDOR INTEREST							
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$ 991	991		
14. Insurance							
a. Insurance on Property (buildings only)				\$ 1,337	1,337		
b. Insurance on Automobiles				\$ 2,871	2,871		
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$ 10,920	10,920		
2. Fire and Extended Coverage				\$ 45,910	45,910		
3. Other (Specify)				\$ 16,864	16,864		
SEE ATTACHED							
14d. Total Insurance Expenditures (14a + b + c)				\$ 77,902	77,902		
15. Total All Expenditures (A-13 thru C-14)				\$ 7,569,161	7,569,161		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
FILOSA FOR NURSING AND REHABILITATION			461-C	9/30/2021	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.	10	A1/A	Salaries not related to Resident Care	\$ 65,862	65,862		
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 16,259	16,259		
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1C	Bad Debts	\$ 24,000	24,000		
10.	15	1E	Accounting	\$ 15,166	15,166		
10a.			Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	L3	Gifts, flowers and coffee shops	\$ 6,224	6,224		
15.	16	L5	Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$ 1,178	1,178		
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	M3	Unallowable Advertising *	\$ 18,899	18,899		
19.	15	9 J K	Income Tax / Corporate Business Tax	\$ (44,954)	(44,954)		
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 11,166	11,166		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$			
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 113,800	113,800		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

**FILOSA FOR NURSING AND REHABILITATION
COST YEAR 2021
LICENSE NO 461-C**

ATTACHMENT TO PAGE 27 OF 37 GENERAL INFORMATION AND QUESTIONNAIRE

INSURANCE PAID

FIDUCIARY	\$	188	
DIRECTORS AND OFFICER PROFESSIONAL LIABILITY		14,673	DISALLOW
CYBER LIABILITY		-	
PRIOR YEAR INSURANCE RELATED ADJ		2,004	
		<u>-</u>	DISALLOW
TOTAL	\$	16,864	14.C.3
Automobile- Santa Fe		820	DISALLOW

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	A2	EXCESS ADMINISTRATOR SALARY	\$ 16,259		
Total Other Salaries Adjustment			\$ 16,259	\$ -	\$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
15	1A4	FICA ON DISALLOWED SALARY	\$ 6,195		
16	M13	MISCELLANEOUS EXPENSE	\$ 1,891		
16	M13	BANK SERVICE CHARGES	\$ 3,080		
Total Other A&G Adjustments			\$ 11,166	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
FILOSA FOR NURSING AND REHABILITATION			461-C	9/30/2021	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 113,800	113,800		
Page 20 - Resident Care Supplies***							
27.	20	5A2	Prescription Drugs	\$ 53,650	53,650		
28.			Ambulance/Limousine	\$			
29.	20	5D	X-rays, etc	\$ 2,600	2,600		
30.	20	5H	Laboratory	\$ 2,009	2,009		
31.	20	5C	Medical Supplies	\$ 10,615	10,615		
32.	20	5E2	Oxygen (non emergency)	\$ 4,472	4,472		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$			
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.	27	14C3	Property Insurance	\$ 15,493	15,493		
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ 3,188	3,188		
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 205,827	205,827		

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

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Ancillary Costs			\$ -	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

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

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

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	13	INTEREST EXPENSE	\$ 5		
16	L6	VEHICLE OPERATING EXPENSE	\$ 3,183		
Total Other Adjustments			\$ 3,188	\$ -	\$ -

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
FILOSA FOR NURSING AND REHABII	461-C	9/30/2021		30	37
Item	Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 6,214,940	6,214,940			
b. Medicaid Room and Board Contractual Allowance **	\$ (2,624,449)	(2,624,449)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,068,920	1,068,920			
b. Medicare Room and Board Contractual Allowance **	\$ 365,173	365,173			
4. a. Private-Pay Residents and Other	\$ 1,746,850	1,746,850			
b. Private-Pay Room and Board Contractual Allowance **	\$ (19,252)	(19,252)			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 98,273	98,273			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (94,092)	(94,092)			
c. Prescription Drugs - Non-Medicare	\$ 7,899	7,899			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (7,899)	(7,899)			
2. a. Medical Supplies - Medicare	\$ 15,715	15,715			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (15,715)	(15,715)			
c. Medical Supplies - Non-Medicare	\$ 2,116	2,116			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (2,116)	(2,116)			
3. a. Physical Therapy - Medicare	\$ 297,741	297,741			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (187,610)	(187,610)			
c. Physical Therapy - Non-Medicare	\$ 22,835	22,835			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (22,835)	(22,835)			
4. a. Speech Therapy - Medicare	\$ 55,964	55,964			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (29,830)	(29,830)			
c. Speech Therapy - Non-Medicare	\$ 3,475	3,475			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (3,475)	(3,475)			
5. a. Occupational Therapy - Medicare	\$ 312,675	312,675			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (208,606)	(208,606)			
c. Occupational Therapy - Non-Medicare	\$ 27,586	27,586			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (27,586)	(27,586)			
6. a. Other (<i>Specify</i>) - Medicare	\$ (190)	(190)			
b. Other (<i>Specify</i>) - Non-Medicare	\$ 4,609	4,609			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 7,001,115	7,001,115			
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>)	\$ 526	526			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ 1,025,718	1,025,718			
V. Total Other Revenue (1 thru 8)	\$ 1,026,244	1,026,244			
VI. Total All Revenue (III +V)	\$ 8,027,359	8,027,359			

* 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)
	PRIOR YEAR ADJUSTMENTS	\$ (190)		
	Total Other Resident Revenue - Medicare	\$ (190)	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	PRIOR YEAR ADJUSTMENTS	\$ 4,609		
	Total Other Resident Revenue	\$ 4,609	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
31	UNION SAVINGS BANK	188,949	\$ 526		
	Total Interest Income		\$ 526	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	MISC. INCOME	\$ 7		
	CARE ACT SICKPAY TAX CREDIT	\$ 3,816		
	MEDICAID STIMULUS PAYMENTS	\$ 59,383		
	SBA - PAYROLL PROTECTION LOAN FORGIVEN	\$ 852,500		
	HHS CARE ACT DEPOSIT	\$ 110,012		
	Total Other Revenue	\$ 1,025,718	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHA	461-C	9/30/2021	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	903,434
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	555,936
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	206,790
a. PREPAID INSURANCE	134,566			
b. FEDERAL CORP TAX LIABILITY	55,000			
c. _____				
d. See Schedule	17,224			
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)			\$	1,666,160
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>868,050</u>		\$	250,458
	Accum. Depreciation <u>617,592</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>620,494</u>		\$	170,649
	Accum. Depreciation <u>449,845</u>	Net		
7. Motor Vehicles	*Historical Cost <u>44,463</u>		\$	
	Accum. Depreciation <u>44,463</u>	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	421,107

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

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
		UTILITIES	\$ 7,089
		LOAN PAYMENT	\$ 1,956
		MAINTENANCE RELATED	\$ 9,687
		OFFICE	\$ (1,508)
Total Prepaid Expenses			\$ 17,224

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	
Total Other Other Fixed Assets (Itemize)			\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

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

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

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

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

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHA		461-C	9/30/2021	32	37
Account				Amount	
Total Brought Forward:				\$	2,087,267
C. Leasehold or like property recorded for Equity Purposes.					
1. Land					
2. Land Improvements					
	*Historical Cost				
	Accum. Depreciation		Net	\$	
3. Buildings					
	*Historical Cost	4,835,483			
	Accum. Depreciation	3,407,227	Net	\$	1,428,256
4. Non-Movable Equipment					
	*Historical Cost	160,751			
	Accum. Depreciation	22,602	Net	\$	138,149
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)				\$	1,566,405
D. Investment and Other Assets					
1. Deferred Deposits					
2. Escrow Deposits					
3. Organization Expense					
	*Historical Cost				
	Accum. Depreciation		Net	\$	
4. Goodwill (Purchased Only)					
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>)					
BED LICENSES			48,001	\$	59,001
DEFERRED TAXES			11,000		
See Schedule					
D-8. Total Investments and Other Assets (Lines D1 thru 7)				\$	59,001
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)				\$	3,712,673

* 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
FILOSA FOR NURSING AND REHABILITATION		461-C	9/30/2021		33	37
Account					Amount	
Liabilities						
A. Current Liabilities						
1. Trade Accounts Payable					\$	352,679
2. Notes Payable (<i>itemize</i>)					\$	

See Schedule						
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)					\$	10,900
Name of Lender		Purpose	Amount	Date Due		
EVERSOURCE		ENERGY EFFICIENCY	7,390	08/07/22		
CAROUSEL INDUSTRIES		TELEPHONE SYSTEM	3,510	02/02/22		
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)					\$	824
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)					\$	183,133
6. Accrued Payroll Taxes Payable					\$	13,032
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*					\$	380
12. Other Current Liabilities (<i>itemize</i>)					\$	300,667
ADVANCE BILLING		51,572				
ACCRUED EXPENSES		17,545				
MEDICAID ADVANCE PAYABLE		65,000				
HHS CARES ACT GRANTS		166,550	See Schedule			
A-13. Total Current Liabilities (Lines A1 thru 12)					\$	861,615

* 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 FILOSA FOR NURSING AND REHABIL		License No. 461-C	Report for Year Ended 9/30/2021	Page 34	of 37
Account				Amount	
Total Brought Forward:				861,615	
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>)				\$ 71,198	
Name and Address of Lender	Amount	Loan Date			
HANCOCK HALL, 31 STAPLES ST DANBURY CT 06810	71,198	ON DENAND			
4. Other Long-Term Liabilities (<i>itemize</i>)				\$	
_____ _____ See Schedule					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 71,198	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 932,813	

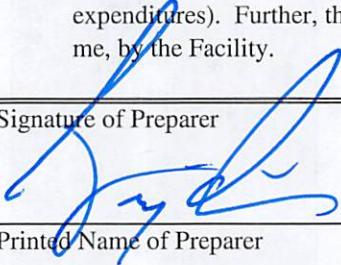
G. Balance Sheet (cont'd)
Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHA	461-C	9/30/2021	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			\$	1,566,405
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			\$	1,566,405
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	90,310
3. Paid-in Surplus			\$	183,510
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	474,269
6. Gain or Loss for Period			\$	465,366
	10/10/2020	thru	9/30/2021	
7. Total Net Worth			\$	1,213,455
C. Total Reserves and Net Worth			\$	2,779,860
D. Total Liabilities, Reserves, and Net Worth			\$	3,712,673

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
FILOSA FOR NURSING AND REHAB	461-C	9/30/2021	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2020			\$	734,104
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	8,027,359
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	7,569,161
D. Net Income or Deficit			\$	458,198
E. Balance			\$	1,192,302
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
BAMCO DEPRECIATION CUMULATIVE			21,153	
F-3. Total Additions			\$	21,153
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			\$	1,213,455
				09/30/21

I. Preparer's/Reviewer's Certification

Name of Facility FILOSA FOR NURSING AND	License No. 461-C	Report for Year Ended 9/30/2021	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<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 CFO	Date Signed 2/14/22		
Printed Name of Preparer BENJAMIN CHIANESE, CPA				
Address Address 31 STAPLES STREET		Phone Number 203-794-9466		
Contacted Person Regarding Additional Information Needed Regarding This Report BENJAMIN CHIANESE, CPA		Phone Number 203-794-9466		
Contact Email Address BCHIANESE@FILOSA.COM				