February 14, 2022

Ms. Nicole Godburn
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105
Attention: Office of Reimbursement and CON

Dear Ms. Godburn:

Enclosed please find the 2021 Medicaid Cost Report for New Milford Rehabilitation, LLC. In preparing this cost report, we did not perform any disallowances for dues expense in excess of the limits for each prescribed by your department. We also did not perform any disallowances related to physical therapy and speech therapy, which were paid for by entities other than the Medicaid Program. We did not disallow bad debts as it is netted against Private Pay Revenue. Page 23 only includes assets which were acquired by New Milford Rehabilitation subsequent to the purchase of the facility. The original purchase of building and equipment is recorded on the books of the management company at acquisition values. As this is a for-profit facility, building and non-moveable equipment value for fair rental purposes should be maintained at the prior owner basis which is recorded in the rate system for the facility. Moveable equipment assets which were acquired have been maintained for this filing at the basis of the prior owner and depreciation expense has been added to page 29 for these assets. Further, we did not disallow any depreciation or interest expense in excess of amounts previously approved via Certificate of Need or related to any prior state desk review or field audits. We believe that these disallowances are performed by the software used by your department in the preparation of the facility's rate computation report, and we do not want to create an inadvertent duplication of disallowance by calculating these adjustments. We believe this preparation methodology is in compliance with any rules and regulations of your department and the federal government.

State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2021

Name of Facility (as licensed) New Milford Rehabilitation, LLC		
Address (No. & Street, City, State, Zip Code) 30 Park Lane East, New Milford, CT 06776		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2207C			07-5416

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	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 IMPRISIONMENT UNDER STATE OR FEDERAL LAW.

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

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility New Milford Rehabilitation, LLC	Period Covered:		From 10/1/2020	To 9/30/2021
Address of Facility 30 Park Lane East, New Milford, CT 06776				
Report Prepared By CliftonLarsonAllen LLP	Phone Number 860-561-4000		Date 2/14/2022	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-355-0971	9/30/2021	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
New Milford Rehabilitation, LLC	30 Park Lane East, New Milford, CT 06776

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2207C			07-5416

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Type of Ownership (Check appropriate box)

○ Proprietorship ◉ LLC ○ Partnership ○ Profit Corp. ○ Non-Profit Corp. ○ Government ○ Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
Erica Roman		001948

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
New Milford Rehabilitation, LLC	30 Park Lane East, New Milford, CT 06776	Connecticut

Name of Partners/Members	Business Address	Title	% Owned
YMW CT, LLC	1165 King Street, Greenwich, CT 06831	Owner	7.06%
SJJJ, LLC	1165 King Street, Greenwich, CT 06831	Owner	7.06%
GW Holdings, LLC	1165 King Street, Greenwich, CT 06831	Owner	54.11%
IK Greenwich, LLC	1165 King Street, Greenwich, CT 06831	Owner	7.06%
WCTHC, LLC	1165 King Street, Greenwich, CT 06831	Owner	24.71%

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2021	3A	37

If this facility is owned or operated as a corporation, provide the following information:

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

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
N/A			
Names of Stockholders Owning at Least 10% of Shares			
N/A			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2021	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Moshe Bernstein	1165 King Street, Greenwich, CT 06831	○	⊙		Management Services	16 m12	60,000	60,000
Mordi Blass	1165 King Street, Greenwich, CT 06831	○	⊙		Management Services	16 m12	60,000	60,000
Sparkle	1165 King Street, Greenwich, CT 06831	⊙	○	60%	Housekeeping Services	20 4b	316,991	300,396
Sparkle	1165 King Street, Greenwich, CT 06831	⊙	○	60%	Laundry Services and Equipment	19 3b and 3d	101,388	96,080
Sparkle	1165 King Street, Greenwich, CT 06831	⊙	○	60%	Medical Supplies	20 Line 5c	2,279	2,160
NMHC Realty, LLC	1165 King Street, Greenwich, CT 06831	○	⊙		Rental Expense	22 Line 9	1,539,978	1,539,978
NMHC Realty, LLC	1165 King Street, Greenwich, CT 06831	○	⊙		Property Insurance	27 Line 14a	27,449	27,449
NMHC Realty, LLC	1165 King Street, Greenwich, CT 06831	○	⊙		Real Estate Taxes	22 Line 10b	127,573	127,573
Skilled Marketing Solutions	1165 King Street, Greenwich, CT 06831	⊙	○	95%	Website Services	16 Line m3	1,188	1,188

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (*See listing page 13*)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

The preparer of this report must answer the following questions applicable to the cost information provided.

1. In the preparation of this Report, were all costs allocated as required? ⊙ Yes ○ No If "No," explain fully why such allocation was not made.

2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

⊙ Yes ○ No If "No," explain fully why such allocation was not made.

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
TIAA Copier, 245 Park Avenue New York, NY 10167	○	⊙	Copier	11/09/18	63 Months	3,612	3,612
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total** *** 3,612

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

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General Information and Questionnaire
Accounting Basis

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 See Attached	
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	See Attached	$ 40,533
2		$
3		$
4		$
		Charge for Services Provided $ 40,533

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

⊙ Yes ○ No Page 15 Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 See Attached	
2	
3	
4	
5	

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	See Attached	$ 8,247
2		$
3		$
4		$
5		$
		Charge for Services Provided $ 8,247

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

⊙ Yes ○ No Page 15 Line 1e

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation	2207C	09/30/2021	7a	37

Vendor	Description	Amount
CliftonLarsonAllen LLP	Medicare and Medicaid cost report preparation	12,700
Bonadio & Co LLP	401k audit	5,333
SY Consultant	Consulting	18,000
Pease CPAs	Partnership Taxes	4,500
		40,533

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation	2207C	9/30/2021	7b	37

Ref	Description	Amount	Disallowed
Goldman, Gruder & Woods, LLC	Collections & General Legal Matters	$ 8,030	8,030
Robinson and Cole LLP	General Legal Matters	157	
Susan Corbett, Marshall	Marshall Fee	60	
		$ 8,247	$ 8,030

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	148	148			148	148						
B. On last day of THIS report period	148	148							148	148		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	113	113			113	113						
B. As of midnight of THIS report period	126	126							126	126		
3. Total Number of Days Care Provided During Period												
A. Medicare	7,152	7,152			5,286	5,286			1,866	1,866		
B. Medicaid (Conn.)	25,658	25,658			19,059	19,059			6,599	6,599		
C. Medicaid (other states)												
D. Private Pay	6,663	6,663			4,841	4,841			1,822	1,822		
E. State SSI for RCH												
F. Other (Specify) VA	2,725	2,725			2,005	2,005			720	720		
G. Total Care Days During Period (3A thru F)	42,198	42,198			31,191	31,191			11,007	11,007		
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	96	96			79	79			17	17		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	42,294	42,294			31,270	31,270			11,024	11,024		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2021	9	37

4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.

Change in Resident Days	CCNH	RHNS	(Specify)
1st change			
2nd change			
3rd change			
4th change			

6. Number of Residents and Rates on September 30 of Cost Year

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	25	70		31				
Per Diem Rate								
a. One bed rm.	N/A	N/A		N/A				
b. Two bed rms.	PDPM	273.70		450.00				
c. Three or more bed rms.	N/A	N/A		N/A				

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	3,467	3,467		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	12,638	12,638		
D. ***Total Physical Therapy Treatments***	16,105	16,105		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	440	440		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	994	994		
D. ***Total Speech Therapy Treatments***	1,434	1,434		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,442	1,442		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	9,884	9,884		
D. ***Total Occupational Therapy Treatments***	11,326	11,326		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2021	10	37

Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	165,330	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	236,430	9,309				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	61,517	2,080				
c. Dietary Workers	436,223	24,266				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	60,062	2,080				
b. Other Maintenance Workers	43,571	2,080				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	200,234	4,232				
b. RN						
1. Direct Care	1,152,977	27,996				
2. Administrative**	347,416	5,313				
c. LPN						
1. Direct Care	1,460,795	48,972				
2. Administrative**	61,640	2,080				
d. Aides and Attendants	1,956,461	112,003				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	164,940	8,420				
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	274,077	8,131				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	169,844	7,612				
A-13. Total Salary Expenditures	6,791,517	266,654				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Wages - Other Nursing Admin	$ 169,844	7,612				
Total	$ 169,844	7,612	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Nursing Admin Purchased Services	$ 58,200	638				
Nursing Admin Purchased Services - Disallowed	$ 23,735	Disallowed				
Total	$ 81,935	638	$ -	-	$ -	-

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
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.

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	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* **										
David Segal	165,330			Same as employee	Administrator	2,080	A2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	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						
2. Dentist	7,800	Disallowed				
3. Pharmacist	2,446	Disallowed				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	382,839	4,182				
b. Other						
6. Social Worker						
7. Recreation Worker	2,335	20				
8. Physicians						
a. Medical Director (entire facility)	42,110	221				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	12,000	Disallowed				
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
Staff Medical Meetings	91	1				
9. Speech Therapist						
a. Resident Care	74,782	770				
b. Other						
10. Occupational Therapist						
a. Resident Care	270,524	3,019				
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	81,935	638				
B-13 Total Fees Paid in Lieu of Salaries	876,862	8,851				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2021	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
See Attached		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
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		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation	2207C	9/30/2021	14a	37

G/L Account #	Direct Care Consultant	Company/Individual Name	Full Explanation of Services	Total Fee Paid*	Total Hours Worked
87110.000	Dentist	CT Dental Group	Dentistry	7,800	Disallowed
85050.000	Pharmacist	Omnicare of Connecticut	Pharmacy	2,446	Disallowed
80950.000 80980.000	Physical Therapy	Preferred Therapy Solutions	Physical Therapy	382,839	4,182
61660.000	Recreation Worker	Various - see Pg. 14b	Recreation	2,335	20
87100.000	Medical Director	Ken Marici	Medical Director	42,110	221
87100.000	Rehab Director	John Mullen	Rehab Director	12,000	Disallowed
87105.000	Utilization Review	Burton R Rubin MD	Medical Staff Meeting	91	1
82950.000 82980.000	Speech Therapist	Preferred Therapy Solutions	Speech Therapy	74,782	770
81950.000 81980.000	Occupational Therapist:	Preferred Therapy Solutions	Occupational Therapy	270,524	3,019
67850.000	Nursing Admin Purchased Services	Acute Care Gases	Oxygen supply	200	Disallowed
		Danbury Hospital	MDs	909	Disallowed
		Health Drive Podiatry	Rehab	26	Disallowed
		Kenneth Marici, MD, PC	MDs	2,572	Disallowed
		MobilexUSA	MDs	161	Disallowed
		Preferred Therapy Solutions	MDs	15,867	Disallowed
		Swallowing Diagnostics LLC	MDs	2,520	Disallowed
		US Labratories	MDs	774	Disallowed
		Western Connecticut Health Network Foundation Inc.	MDs	468	Disallowed
		Western Connecticut Medical Group	MDs	239	Disallowed
				23,735	-
		Teresa Skinner	MDs	58,200	638
				58,200	638
			Total Fees	***876,862***	***8,851***

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

Name of Facility		License No.		Report for Year Ended	Page	of
New Milford Rehabilitation		2207C		9/30/2021	14b	37

Activities Entertainment

Entertainment	Description	Date	Total Paid
Danny Russo	Entertainment	5/12/2021	$200.00
James I. Moore	Entertainment	5/20/2021	$100.00
Frank Palmer	Entertainment	5/27/2021	$100.00
Danny Russo	Entertainment	6/3/2021	$125.00
Joel Blumert	Entertainment	6/24/2021	$100.00
Bill Michael	Entertainment	6/10/2021	$110.00
James I. Moore	Entertainment	6/17/2021	$100.00
Dean Snellback	Entertainment	6/1/2021	$125.00
Danny Russo	Entertainment	7/1/2021	$125.00
Frank Palmer	Entertainment	7/15/2021	$100.00
James I. Moore	Entertainment	7/8/2021	$100.00
James I. Moore	Entertainment	7/22/2021	$100.00
Frank Palmer	Entertainment	8/26/2021	$100.00
Dean Snellback	Entertainment	8/16/2021	$125.00
Dean Snellback	Entertainment	8/1/2021	$125.00
Danny Russo	Entertainment	9/2/2021	$125.00
Danny Russo	Entertainment	9/12/2021	$125.00
Joel Blumert	Entertainment	9/9/2021	$125.00
Frank Palmer	Entertainment	9/30/2021	$100.00
Dean Snellback	Entertainment	9/30/2021	$125.00
		Total Activities & Entertainment	$2,335.00

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2021	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	249,776	249,776		
2. Disability Insurance	$				
3. Unemployment Insurance	$	76,296	76,296		
4. Social Security (F.I.C.A.)	$	501,123	501,123		
5. Health Insurance	$	1,107,680	1,107,680		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	26,372	26,372		
(not-owners and not-operators)					
8. Uniform Allowance	$	2,500	2,500		
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	40,533	40,533		
e. Legal (*Services should be fully described on Page 7)*	$	8,247	8,247		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	31,694	31,694		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	24,508	24,508		
2. Cellular Phones	$	2,778	2,778		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$	600,355	600,355		
2. Other (*Specify*)	$	382,848	382,848		
See Attached Schedule					
3. Resident Day User Fee	$	724,812	724,812		
Subtotal	$	3,779,522	3,779,522		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Business Taxes - Disallowed	$ 382,848		
Total	$ 382,848	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2021	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		3,779,522	3,779,522		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$	21,074	21,074		
4. Employee Travel	$	2,897	2,897		
5. Education Expenses Related to Seminars and Conventions	$	22,721	22,721		
6. Automobile Expense (*not purchase or depreciation*)	$	39,454	39,454		
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	10,814	10,814		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	30,340	30,340		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	5,018	5,018		
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	8,163	8,163		
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	330	330		
9. Subscriptions	$	8,085	8,085		
10. Contributions***	$	10,124	10,124		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	48,846	48,846		
12. Administrative Management Services**	$	120,000	120,000		
13. Other (*Specify*)	$	134,025	134,025		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	4,241,413	4,241,413		

* 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)
Business Promotions - Disallowed	$ 29,847		
Other Advertising - Disallowed	$ 493		
Total Other Advertising	$ 30,340	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Dues - See pg 16b	$ 8,163		
Total Dues	$ 8,163	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
American Cancer Society	$ 8,691		
Alzheimer's Association	$ 1,183		
Ostomy Awareness Foundation	$ 250		
Total Contributions	$ 10,124	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Employee Background Checks	$ 4,679		
Data Processing Fees	$ 34,224		
Software Maintenance	$ 65,156		
Insurance - ELPI	$ 9,883		
Insurnace - Bond	$ 888		
Facility Licenses	$ 5,441		
Bank Charges	$ 11,314		
Insurance - Crime	$ 2,440		
Total Other Administrative and General	$ 134,025	$ -	$ -

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Detail of Dues and Subscriptions

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation	2207C	9/30/2021	16b	37

Description	Total Amount	Dues	Subscriptions	Chamber of Commerce
Allscripts Healthcare, LLC	4,394		4,394	
Hearst Media Services, CT, LLC	2,593		2,593	
Language Line Services	300		300	
Amex - Disallowed	640		640	
Amazon Prime Annual Subscription	158		158	
New Milford Chamber of Commerce - Disallowed	330			330
NaviHealth Membership	8,032	8,032		
Housatonic Business Association Membership	131	131		
	$ 16,578	$ 8,163	$ 8,085	$ 330

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
New Milford Rehabilitation, LLC	2207C	9/30/2021	17 | 37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Moshe Bernstein	60,000	Management Services	16 m12
Mordi Blass	60,000	Management Services	16 m12

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

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

Name of Facility	License No.	Report for Year Ended	Page of
New Milford Rehabilitation, LLC	2207C	9/30/2021	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	252,164	252,164		
2. Non-Food Supplies	$	21,198	21,198		
3. Other (*Specify*)_____ Chemicals / Cleaning Supplies	$	9,346	9,346		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____ Nutritional Supplements	$	17,199	17,199		
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	299,907	299,907		

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
New Milford Rehabilitation, LLC	2207C	9/30/2021	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. $	430	430		
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	273,163	273,163		
c. Other (*Specify*) Supplies $600 / Housekeeping Chemicals $188	$	788	788		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	274,381	274,381		

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2021	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	42,476	42,476		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	316,991	316,991		
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	359,467	359,467		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	281,726	281,726		
Medicare $248,117, Medicaid $14,117, Managed Care $18,880, Ever Care $612						
b. Medicine Cabinet Drugs		$	24,243	24,243		
c. Medical and Therapeutic Supplies		$	129,342	129,342		
d. Ambulance/Limousine***		$	33,858	33,858		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	3,784	3,784		
f. X-rays and Related Radiological Procedures***		$	24,475	24,475		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	48,799	48,799		
i. Recreation		$	4,642	4,642		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)****		$	200,769	200,769		
See Attached Schedule						
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	751,638	751,638		

* 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)
Specialty Mattresses - Disallowed	$ 33,652		
Cable TV - Disallowed	$ 17,915		
OT Small Equipment Purchase - Disallowed	$ 581		
PT Equipment Rental - Disallowed	$ 16,590		
Nursing Supplies - Partially Disallowed	$ 124,051		
Wound Care Supplies	$ 7,980		
Total Other Resident Care	$ 200,769	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2021	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
Viventium	1000, Berkeley Heights, NJ 07922	○	⊙		Payroll	29,140			16	m13
All American Waste	PO Box 630, E. Windsor, CT 06088	○	⊙		Trash Removal	28,483			22	6f
Image First	PO Box 61323, King of Prussia, PA 19406	○	⊙		Laundry	160,719			19	3b
Crown Care	PO Box 86, Lakewood, NJ 08701	○	⊙		Storage / Shredding Fees	16,255			22	6f
MatrixCare	Bin #32 PO Box 1414, Minneapolis, MN 55480	○	⊙		Health Care Software Payables	53,445			16	m13
Rinaldi Linen Service	47 Commons Court, Waterbury, CT 06704	○	⊙		Laundry	11,056			19	3b
Shamrock	Road, Monroe, CT 06468	○	⊙		Landscaping	32,245			22	6f
Saucier	148 North Street, Plantsville, CT 06479	○	⊙		HVAC	31,279			22	6a
Sparkle	1165 King Street, Greenwich, CT 06831	⊙	○	Common Ownership	Laundry	101,388			19	3b
Smartlinx	PO Box 22598, NY, NY 10087	○	⊙		Payroll Software Program	10,557			16	m13
Sparkle	1165 King Street, Greenwich, CT 06831	⊙	○	Common Ownership	Housekeeping	316,991			20	4b
		○	⊙							
		○	⊙							
		○	⊙							

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

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

Name of Facility	License No.	Report for Year Ended	Page
New Milford Rehabilitation, LLC	2207C	9/30/2021	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	66,085	66,085		
b. Heat	$	109,327	109,327		
c. Light & Power	$	146,745	146,745		
d. Water	$	64,760	64,760		
e. Equipment Lease (*Provide detail on page 6*)	$	3,612	3,612		
f. Other (*itemize*)	$	159,492	159,492		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	550,021	550,021		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	64,524	64,524		
c. Non-Movable Equipment	$	1,652	1,652		
d. Movable Equipment	$	27,120	27,120		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	93,296	93,296		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$				
9. Rental payments on leased real property less real estate taxes included in item 10b	$	1,539,978	1,539,978		
10. Property Taxes					
a. Real estate taxes paid by owner	$	127,573	127,573		
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	26,950	26,950		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,787,797	1,787,797		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Trash Removal / Shredding	$ 45,977		
Service Contracts	$ 24,753		
Plant Supplies	$ 28,951		
Grounds Maintenance	$ 47,839		
Grounds Landscaping	$ 49		
Plant Purchased Services - Disallowed	$ 200		
A&G Equipment Rental	$ 7,549		
Minor Decorating - Disallowed	$ 298		
Copy Charges	$ 2,852		
Charges Not Meeting Criteria for Page 6	$ 1,024		
Total Other Repairs and Maintenance	$ 159,492	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2021	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period	897,583		897,583	115,466	SL	Various	60,420	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	214,787		214,787		SL	Various	4,104	
B-4. Subtotal								64,524
C. **Non-Movable Equipment**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	41,800		41,800		SL	Various	1,652	
C-4. Subtotal								1,652

	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					133,931		133,931	64,861	SL	Various	23,501	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					23,239		23,239		SL	Various	3,619	
D-3. Subtotal												27,120
E. ***Total Depreciation***												93,296

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:					
10/31/2020	Remodeling	$ 149,287	15	$ 2,488	
3/31/2021	Stucco	$ 40,000	15	$ 1,333	
7/31/2021	Patio	$ 25,500	15	$ 283	
Total additions for Building Improvements		$ 214,787		$ 4,104	*
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:					
4/30/2021	Call Bells	$ 31,000	10	$ 1,292	
5/31/2021	Washer	$ 10,800	10	$ 360	
Total additions for Non-Movable Equipment		$ 41,800		$ 1,652	*
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:					
10/31/2020	Beds	$ 1,414	5	$ 259	
11/30/2020	Network, WIFI	$ 11,980	5	$ 2,396	
12/31/2020	Network, WIFI	$ 3,225	5	$ 484	
3/31/2021	Beds	$ 1,609	5	$ 161	
5/31/2021	Beds	$ 1,635	5	$ 109	
7/31/2021	Beds	$ 1,919	5	$ 64	
8/31/2021	Computer	$ 1,457	5	$ 146	
Total additions for Movable Equipment		$ 23,239		$ 3,619	*
Deletions:					
Total deletions for Movable Equipment		$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Leasehold Improvement		$ -		$ -	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2021	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense** 1.									
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									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2021	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ◉ Yes ○ No

If "Yes," complete Part B.
If "No," complete Part C.

*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	04/01/16
4. Date of Initial Licensure	04/01/16
5. Total Licensed Bed Capacity	148
6. Square Footage	53,395
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Available upon			
b. Date Mortgage Obtained	request			
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of 9/30/2021				
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.

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

Name of Facility	License No.	Report for Year Ended	Page of
New Milford Rehabilitation, LLC	2207C	9/30/2021	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*)

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

Name of Facility	License No.	Report for Year Ended	Page of
New Milford Rehabilitation, LLC	2207C	9/30/2021	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*) $				
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*) $ Insurance Notes	1,588	1,588		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	1,588	1,588		
14. Insurance				
a. Insurance on Property (buildings only) $	27,449	27,449		
b. Insurance on Automobiles $	6,494	6,494		
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	16,640	16,640		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $ Liability	77,960	77,960		
14d. ***Total Insurance Expenditures (14a + b + c)*** $	128,543	128,543		
15. ***Total All Expenditures (A-13 thru C-14)*** $	16,063,134	16,063,134		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
New Milford Rehabilitation, LLC	2207C	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.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $	66,487	66,487		
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	b10a	Occupational Therapy $	270,524	270,524		
7.			Other - See attached Schedule $	48,607	48,607		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $				
10.			Accounting $				
10a.			Legal $	8,030	8,030		
11.			Telephone $				
12.	15	1h2	Cellular Telephone $	1,698	1,698		
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.	16	l6	Automobile Expense (e.g. personal use) $	25,809	25,809		
18.	16	m3	Unallowable Advertising * $	30,340	30,340		
19.	16	1k2	Income Tax / Corporate Business Tax $	983,203	983,203		
20.	16	m10	Fund Raising / Contributions $	10,124	10,124		
21.	16	m12	Unallowable Management Fees $	120,000	120,000		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	59,684	59,684		
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) $	1,624,506	1,624,506		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	A4	Admissions - Marketing Duties	$ 11,822		
10	A2	Administrator over Allowable	$ 54,665		
Total Other Salaries Adjustment			$ 66,487	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	b12	Nursing Admin Purchased Services	$ 23,735		
13	b2	Dentist	$ 7,800		
13	b3	Pharmacist	$ 2,446		
13	8a	Medical Director over Allowable	$ 2,626		
13	8c	Rehab Director Resident Care	$ 12,000		
Total Other Fees Adjustments			$ 48,607	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	13	Employee Relations	$ 21,074		
20	4b	Housekeeping Purchased Services - Disallow markup on related party service	$ 16,595		
19	3b	Laundry Purchased Services - Disallow markup on related party services	$ 5,308		
		Benefits on Disallowed Salary above	$ 13,297		
16	m13	Crime Insurance	$ 2,440		
16	m8a	Chamber of Commerce Dues	$ 330		
16	m9	AmEx Membership	$ 640		
Total Other A&G Adjustments			$ 59,684	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2021	29	37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	1,624,506	1,624,506		
Page 20 - Resident Care Supplies*							
27.	20	5a2	Prescription Drugs $	281,726	281,726		
28.	20	5d	Ambulance/Limousine $	33,858	33,858		
29.	20	5f	X-rays, etc $	24,475	24,475		
30.	20	5h	Laboratory $	48,799	48,799		
31.	20	5c	Medical Supplies $	23,781	23,781		
32.	20	5e2	Oxygen (non emergency) $	3,784	3,784		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	97,153	97,153		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $	(5,821)	(5,821)		
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 $	498	498		
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Other - Indirect $				
43.			Interest Income on Account Rec. $				
44.			Other - Miscellaneous Administrative $				
45.			Management Fees Direct $				
46.			Management Fees Indirect $				
47.			Other - Direct $	84,850	84,850		
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
49.			***Total Amount of Decrease (Items 1 - 48)*** $	2,217,609	2,217,609		

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

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5l	Medical Supplies % of Nursing/Incontinent/Wound Care Supplies	$ 46,211		
20	5l	OT Small Equipment Purchase	$ 581		
20	5l	PT Equipment Rental	$ 16,590		
20	5l	Specialty Mattresses	$ 33,652		
20	5c	Medical Supplies - Disallow markup on related party services	$ 119		
Total Other Ancillary Costs			$ 97,153	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
		To include depreciation expense at prior owner basis which	$ (5,821)		
		were purchased by new owner.			
Total Excess Movable Equipment Depreciation			$ (5,821)	$ -	$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	6f	Minor Decorating	$ 298		
22	6f	Plant Purchased Services	$ 200		
Total Other Property Adjustments			$ 498	$ -	$ -

Schedule of Other - Indirect Adjustments

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

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	12d	Interest Expense	$ 1,533		
20	5J	Cable TV	$ 17,915		
30	IV8	Miscellaneous Income	$ 55,993		
30	IV5	Interest Income	$ 9,409		
Total Other Adjustments			$ 84,850	$ -	$ -

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
New Milford Rehabilitation, LLC	2207C	9/30/2021	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	12,080,160	12,080,160		
b. Medicaid Room and Board Contractual Allowance **	$	(5,585,553)	(5,585,553)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	3,233,432	3,233,432		
b. Medicare Room and Board Contractual Allowance **	$	1,558,229	1,558,229		
4. a. Private-Pay Residents and Other	$	3,929,297	3,929,297		
b. Private-Pay Room and Board Contractual Allowance **	$	(515,302)	(515,302)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	244,092	244,092		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(244,092)	(244,092)		
c. Prescription Drugs - Non-Medicare	$	114,613	114,613		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(89,645)	(89,645)		
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	528,894	528,894		
b. Physical Therapy - Medicare Contractual Allowance **	$	(468,115)	(468,115)		
c. Physical Therapy - Non-Medicare	$	171,021	171,021		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(115,926)	(115,926)		
4. a. Speech Therapy - Medicare	$	124,193	124,193		
b. Speech Therapy - Medicare Contractual Allowance **	$	(103,343)	(103,343)		
c. Speech Therapy - Non-Medicare	$	65,468	65,468		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(39,270)	(39,270)		
5. a. Occupational Therapy - Medicare	$	434,407	434,407		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(409,015)	(409,015)		
c. Occupational Therapy - Non-Medicare	$	93,850	93,850		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(69,234)	(69,234)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	4,016	4,016		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	14,942,177	14,942,177		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	9,409	9,409		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	3,505,021	3,505,021		
V. Total Other Revenue (1 thru 8)	$	3,514,430	3,514,430		
VI. Total All Revenue (III +V)	$	18,456,607	18,456,607		

* *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)
30/6a	Oxygen Medicare A	$ 445		
30/6a	X-Ray Medicare A	$ 21,610		
30-6a	LAB Medicare A	$ 39,510		
30-6a	Less: Contractual Adjustment	$ (61,565)		
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30/6b	LAB EverCare	$ 3,056		
30/6b	Oxygen Managed Care	$ 304		
30/6b	X-Ray Managed Care	$ 4,766		
30/6b	LAB Managed Care	$ 6,547		
30/6b	Less: Contractual Agreement	$ (10,657)		
Total Other Resident Revenue		$ 4,016	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30/IV5	Interest Income		$ 9,409		
Total Interest Income			$ 9,409	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30/IV8	Miscellaneous Income - Disallowed	$ 55,993		
30/IV8	Optum Program Revenue	$ 118,106		
30/IV8	Government Stimulus	$ 1,753,887		
30/IV8	Employee Retention Credits	$ 1,577,035		
Total Other Revenue		$ 3,505,021	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2021	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 969,051
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,240,957
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 5,028,778
4 Inventories				$
5. Prepaid Expenses				$ 133,428
a. Expenses		4,678		
b. Insurance		115,468		
c. Sewer		6,914		
d. See Schedule		6,368		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 92,229
Patient Funds Held in Trust		92,229		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 7,464,443
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost	1,112,370		$ 932,380
	Accum. Depreciation	179,990	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	41,800		$ 40,148
	Accum. Depreciation	1,652	Net	
6. Movable Equipment	*Historical Cost	157,170		$ 65,189
	Accum. Depreciation	91,981	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 23,241
Construction in Progress		23,241		
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 1,060,958

* 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	
31	A4d	Taxes	$ 6,368
Total Prepaid Expenses			$ 6,368

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)			$ -

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2021	32	37

Account				Amount
			Total Brought Forward:	$ 8,525,401
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			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 36,395
Deposits		36,395		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 36,395
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 8,561,796

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2021	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 640,538
2. Notes Payable (*itemize*)					$ 4,884
Loan Payable - AW	4,884				
See Schedule					
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)					$ 396,419
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$ 2,581,042
Deferred Revenue	41,000	Accrued Provider User Fe	188,991		
Resident Trust	92,229				
Accrued Operating Expenses	566,334				
Accrued Liabilities Other	1,692,488	See Schedule			
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 3,622,883

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2021	34	37

Account	Amount
Total Brought Forward:	3,622,883
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)		$ 6,695
Due to NMHC Realty Co.	6,695	
See Schedule		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 6,695
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 3,629,578

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

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2021	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	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$ 2,538,745
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$
	6. Gain or Loss for Period 10/1/2020 thru 9/30/2021	$ 2,393,473
	7. Total Net Worth	$ 4,932,218
C.	***Total Reserves and Net Worth***	$ 4,932,218
D.	***Total Liabilities, Reserves, and Net Worth***	$ 8,561,796

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2021	36	37

Account	Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2020	$ 2,538,745
B. Total Revenue (*From Statement of Revenue Page 30*)	$ 18,456,607
C. Total Expenditures (*From Statement of Expenditures Page 27*)	$ 16,063,134
D. Net Income or Deficit	$ 2,393,473
E. Balance	$ 4,932,218
F. Additions	
1. Additional Capital Contributed (*itemize*)	
2. Other (*itemize*)	
F-3. Total Additions	$
G. Deductions	
1. Drawings of Owners/Operators/Partners (*Specify*)	$

Name and Address (*No., City, State, Zip*)	Title	Amount

2. Other Withdrawings *(Specify)*	$
Purpose	Amount
3. Total Deductions	$
H. ***Balance at End of Period*** 09/30/21	$ 4,932,218

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Rehabilitation, LLC	2207C	9/30/2021	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed
CliftonLarsonAllen LLP		2/14/2022

Printed Name of Preparer	
CliftonLarsonAllen LLP	
Addres Address	Phone Number
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