

# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2021

Name of Facility (as licensed) Senior Philanthropy of Milford O, LLC d/b/a West River Rehab Center	
Address (No. & Street, City, State, Zip Code) 245 Orange Ave., Milford, CT 06461	
Type of Facility <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)	
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

License Numbers:	CCNH 2404	RHNS	(Specify)	Medicare Provider 07-5377
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Medicaid Provider Numbers:	CCNH 20925	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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### General Information

Name of Facility (as licensed) Senior Philanthropy of Milford O, LLC d/b/a West Riv	License No. 2404	Report for Year Ended 9/30/2021	Page 1	of 37
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#### Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Senior Philanthropy of Milford O, LLC d/b/a West River Rehab Center [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) T. Kevin Cleary			Printed Name (Owner)		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires  / /	
Address of Notary Public					

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Senior Philanthropy of Milford O, LLC d/b/a West River Rehab Center		Period Covered:	From 10/1/2020	To 9/30/2021
Address of Facility 245 Orange Ave., Milford, CT 06461				
Report Prepared By CJLC LLC		Phone Number 860-610-9009	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. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

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

Phone No. of Facility 203-876-5123		Report for Year Ended 9/30/2021	Page 2	of 37
Name of Facility (as shown on license) Senior Philanthropy of Milford O, LLC d/b/a West River Reha		Address (No. & Street, City, State, Zip) 245 Orange Ave., Milford, CT 06461		
License Numbers:	CCNH 2404	RHNS (Specify)	Medicare Provider No. 07-5377	
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.				
<b>Administrator</b>				
Name of Administrator T. Kevin Cleary		Nursing Home Administrator's License No.:	1401	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name N/A		License No.:		









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

Name of Facility Senior Philanthropy of Milford O, LLC d/b/a West Rive	License No. 2404	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	%**				
Eagle Lake Foundation, Inc.	24641 US Hwy 19 N., Clearwater, FL 33763-8007	<input type="radio"/>	<input checked="" type="radio"/>		AHT Fees, Health Insurance, Accounting Fee	Various	1,592	1,592
Cheshire Regional Rehab Center	745 Highland Ave., Cheshire, CT 06410	<input type="radio"/>	<input checked="" type="radio"/>		Shared Staff - Regional Admissions	Various		
Traditions Senior Management	24641 US Hwy 19 N., Clearwater, FL 33763-8007	<input type="radio"/>	<input checked="" type="radio"/>		Internet, Recruitment, IT Support	Various	145,449	145,449
Newington Rapid Recovery	240 Church Street, Newington, CT 06111	<input type="radio"/>	<input checked="" type="radio"/>		Loan Interest, MDS Shared Staff, Bank Fees,	Various	2,280,451	2,280,451
Traditions Senior Management	24641 US Hwy 19 N., Clearwater, FL 33763-8007	<input type="radio"/>	<input checked="" type="radio"/>		Management Company	16/m12	60,617	60,617
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

\* Use additional sheets if necessary.

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

## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility Senior Philanthropy of Milford O, LLC d/b/a W	License No. 2404	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.

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

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

## General Information and Questionnaire 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 Senior Philanthropy of Milford O, LLC d/b/a West River Rd			License No. 2404	Report for Year Ended 9/30/2021			Page 6	of 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						
N/A	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes <input checked="" type="radio"/> No	<b>Total ***</b>

\* 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 Senior Philanthropy of Milford O, I	License No. 2404	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 1 CJLC LLC 2 Marcum LLP 3 Roy & Pape, LLC 4	Address (No. & Street, City, State, Zip Code) 225 Pitkin St., East Hartford, CT 06108 555 Long Wharf Drive, 8th Fl., New Haven, CT 06511
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Services Provided by This Firm (*describe fully*)

1 Medicaid Cost Report Preparation	\$ 7,843
2 Accrued Accounting Expnese	\$ 1,227
3 Audit Services	\$ 8,210
4 Reduction of Liability Accrual	\$ (31,022)
	Charge for Services Provided \$ (13,742)

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

**Legal Services Information**

Name of Legal Firm or Independent Attorney 1 See schedule. 2 3 4 5	Telephone Number
---	------------------

Address (*No. & Street, City, State, Zip Code*)  
 1  
 2  
 3  
 4  
 5

Services Provided by This Firm (*describe fully*)

1	\$ 19,844
2	\$
3	\$
4	\$
5	\$
	Charge for Services Provided \$ 19,844

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

West River  
 Legal Sch  
 9/30/2021

VENDOR	DESCR	AMT
AMERICAN ARBITRATION ASSOCIATION	SMITH 01-18-0002-4658-2-JM	(275.00)
GOLDMAN GRUDER & WOODS, LLC	WR. G. Robbins	540.00
GOLDMAN GRUDER & WOODS, LLC	WR vs. G. Robbins Legal	4.85
TRADITIONS SENIOR MANAGEMENT Ct Corporation	Littler #5313346	67.67 234.58
Goldman Gruder & Woods, LLC	West river v. robbins, George	\$ 399.40
Goldman Gruder & Woods, LLC	west river v. robbins, george	730.50
Goldman Gruder & Woods, LLC	File#10395-008 - West River Vs Blount, Ronald	3,227.50
Goldman Gruder & Woods, LLC	File#10395-007 - West River vs Robbins, George	660.00
Goldman Gruder & Woods, LLC	west river v. blount, ronald	1,544.08
Goldman Gruder & Woods, LLC	west river v. robbins, george	71.81
Goldman Gruder & Woods, LLC	west river v. brudniak, genowefa	45.00
Contangy, Brooks & Smith, LLP	PY bal clear from AP	(28.42)
Goldman Gruder & Woods, LLC	west river v. robbins, george	280.00
Goldman Gruder & Woods, LLC	west river v. blount, ronald	350.00
Goldman Gruder & Woods, LLC	west river v. brudniak, genowefa	112.50
Goldman Gruder & Woods, LLC	re: ronald blunt conservatorship	35.00
Murtha Cullina LLP	professional services through August 31, 2021	2,110.50
Goldman Gruder & Woods, LLC	re: ronald blunt conservatorship	70.00
Murtha Cullina LLP	professional services through September 30, 2021	3,351.50
210215	INCREASE OF LIABILITY ACCRUAL	\$ 4,500.00
	Conservator fees	\$ 1,813.00 **disallow
		<u>\$ 19,844.47</u>

Schedule of Resident Statistics

Name of Facility		License No.			Report for Year Ended				Page		of	
Senior Philanthropy of Milford O, LLC d/b/a West River Rehab Center		2404			9/30/2021				8		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	120	120			120	120			120	120		
B. On last day of THIS report period	120	120			120	120			120	120		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	97	97			97	97			98	98		
B. As of midnight of THIS report period	100	100			98	98			100	100		
3. Total Number of Days Care Provided During Period												
A. Medicare	6,284	6,284			5,319	5,319			965	965		
B. Medicaid (Conn.)	18,699	18,699			13,227	13,227			5,472	5,472		
C. Medicaid (other states)												
D. Private Pay	2,054	2,054			1,375	1,375			679	679		
E. State SSI for RCH												
F. Other (Specify) HMO,HOS,INS,VA,HMA	4,627	4,627			3,336	3,336			1,291	1,291		
G. Total Care Days During Period (3A thru F)	31,664	31,664			23,257	23,257			8,407	8,407		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. <b>Total Resident Days (3G + 4A + 4B)</b>	31,664	31,664			23,257	23,257			8,407	8,407		

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

Name of Facility Senior Philanthropy of Milford O, LLC d/b/a			License No. 2404			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? <span style="float: right;"><input type="radio"/> Yes <input checked="" type="radio"/> No</span>													
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			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days									CCNH	RHNS	(Specify)		
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	8	64		9			19						
Per Diem Rate													
a. One bed rm.		302.81		601.97									
b. Two bed rms.				529.03									
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									3,135	3,135			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments									1,727	1,727			
2. Restorative Treatments													
C. Other									17,667	17,667			
<b>D. Total Physical Therapy Treatments</b>									22,529	22,529			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									308	308			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments									147	147			
2. Restorative Treatments													
C. Other									1,913	1,913			
<b>D. Total Speech Therapy Treatments</b>									2,368	2,368			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									4,173	4,173			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments									1,726	1,726			
2. Restorative Treatments													
C. Other									21,377	21,377			
<b>D. Total Occupational Therapy Treatments</b>									27,276	27,276			

### Report of Expenditures - Salaries & Wages

Name of Facility Senior Philanthropy of Milford O, LLC d/b/a West River Rel	License No. 2404	Report for Year Ended 9/30/2021	Page 10	of 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
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	156,192	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	135,092	2,170				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	400,255	20,180				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	267,646	13,591				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	117,404	4,060				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	36,083	1,812				
9. Barber and Beautician Services						
10. Protective Services	15,456	796				
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	252,625	4,339				
b. RN						
1. Direct Care	958,317	16,779				
2. Administrative**	313,665	14,681				
c. LPN						
1. Direct Care	980,297	32,275				
2. Administrative**						
d. Aides and Attendants	1,246,767	61,601				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	147,651	5,880				
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	119,897	3,994				
n. Marketing						
o. Other (Specify) See Attached Schedule	81,566	2,195				
<i>A-13. Total Salary Expenditures</i>	5,228,914	186,433				

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

Name of Facility				License No.	Report for Year Ended			Page	of	
Senior Philanthropy of Milford O, LLC d/b/a West River Rehab Center				2404	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)							
<b>Section I - Operators/Owners</b>										
<b>Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).</b>										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
Senior Philanthropy of Milford O, LLC d/b/a West River Rehab Cent				2404	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)							
<b>Section III - Administrators***</b>										
T. Kevin Cleary	156,192			Non-Discrim.	Administrator	2,080	A2			
<b>Section IV - Assistant Administrators</b>										

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of		
Senior Philanthropy of Milford O, LLC d/b/a West I	2404	9/30/2021	13	37		
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian	109,558	1,826				
2. Dentist	8,721	44				
3. Pharmacist	16,723	111				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	389,362	Contract				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	72,000	599				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	(15,189)	(101)				
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	94,779	Contract				
b. Other						
10. Occupational Therapist						
a. Resident Care	482,352	Contract				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	9,350	97				
2. Administrative***	24,011	396				
b. LPN						
1. Direct Care	213,605	4,504				
2. Administrative***						
c. Aides	237,243	5,969				
d. Other						
12. Other (Specify) See Attached Schedule						
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	1,642,515	13,444				

\* 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 Senior Philanthropy of Milford O, LLC d/b/a West River		License No. 2404	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		
Dr. Anuruddha Walaliyada, 12 Cooke Rd., Wallingford, CT 06492	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Partners Pharmacy, PO Box 9689, Uniondale, NY 11555	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>		
Health Drive Dental Group, 888 Worcester St. #130, Wellesley, MA 02482	Dentist	<input type="radio"/>	<input checked="" type="radio"/>		
Partners Pharmacy of CT, PO Box 9689 Uniondale, NY 11555-9689	Utilization Review	<input type="radio"/>	<input checked="" type="radio"/>		
Ready Nurse Staffing, PO Box 301076, Callas, TX 75303-1076	LPN/Aides	<input type="radio"/>	<input checked="" type="radio"/>		
Joseph Balsamo, 687 Campbell Ave., West Haven, CT 06516	Medical Director/PHY Consulting	<input type="radio"/>	<input checked="" type="radio"/>		
Encore Rehabilitation Services, 33533 W 12 Mile Rd., Suite 290, Farmington Hills, MI 48331	PT/OT/ST	<input type="radio"/>	<input checked="" type="radio"/>		
Healthcare Services Group, 3220 Tillman Dr., Suite 300, Bensalem, PA 19020	Dietician	<input type="radio"/>	<input checked="" type="radio"/>		
Certified Languages International LLC, 4800 SW Macadam Ave., Suite 400, Portland, OR 97239	Purchased Services - Interpreter	<input type="radio"/>	<input checked="" type="radio"/>		
Urological Associates of Bridgeport, PO Box 11901, belfast, ME 04915	Purchased Services - Urology	<input type="radio"/>	<input checked="" type="radio"/>		
Affiliated Foot and Ankle Surgeons PC, 580 Blake St., New Haven, CT 06515	Purchased Services - Podiatry	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
Senior Philanthropy of Milford O, LLC d/b/a We	2404	9/30/2021		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 114,217	114,217			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 49,957	49,957			
4. Social Security (F.I.C.A.)	\$ 385,734	385,734			
5. Health Insurance	\$ 857,049	857,049			
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 3,236	3,236			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 164,864	164,864			
8. Uniform Allowance	\$ 21,566	21,566			
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 12,611	12,611			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 726,090	726,090			
d. Accounting and Auditing	\$ (13,672)	(13,672)			
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 19,844	19,844			
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$				
g. Office Supplies	\$ 5,250	5,250			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 61,760	61,760			
2. Cellular Phones	\$ 914	914			
i. Appraisal ( <i>Specify purpose and         attach copy</i> )*	\$				
j. Corporation Business Taxes ( <i>franchise tax</i> )	\$				
k. Other Taxes ( <i>Not related to property - See Page 22</i> )					
1. Income*	\$				
2. Other ( <i>Specify</i> ) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 477,911	477,911			
<b>Subtotal</b>	\$ 2,887,330	2,887,330			

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

(Carry Subtotals forward to next page)



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

Name of Facility	License No.	Report for Year Ended		Page	of
Senior Philanthropy of Milford O, LLC d/b/a West Riv	2404	9/30/2021		16	37
Item	Total	CCNH	RHNS	(Specify)	
<b>Subtotals Brought Forward:</b>		2,887,330	2,887,330		
i. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 964	964			
5. Education Expenses Related to Seminars and Conventions	\$ 27,751	27,751			
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$ 229	229			
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$ 7,261	7,261			
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ (125)	(125)			
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	\$ 3,015	3,015			
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 8,632	8,632			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 4,628	4,628			
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> )	\$ 152,857	152,857			
12. Administrative Management Services**	\$ 60,617	60,617			
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 125,272	125,272			
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 3,278,431	3,278,431			

\* 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)
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
Special Events-Mkt	\$ (126)		
Promo Items-Mkt	\$ 2		
<b>Total Other Advertising</b>	\$ (125)	\$ -	\$ -

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
CT Association of Health Care	\$ 8,632		
<b>Total Dues</b>	\$ 8,632	\$ -	\$ -

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
<b>Total Contributions</b>	\$ -	\$ -	\$ -

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
Software	\$ 4,620		
Licesnes/Permits	\$ 3,850		
Background Checks	\$ 1,702		
Patient Trust Bond	\$ 1,445		
Res Reimburse Lost/Stolen Items	\$ 3,407		
Emergency Costs	\$ 41,985		
Equipment Minor	\$ 5,558		
Internet	\$ 20,378		
Records Storage	\$ 14,115		
Equipment Rental	\$ 2,526		
Collection Fees/Credit Card Fee	\$ 1,840		
Late fees/Fines/Finance Charges	\$ 7,436		
Bank Service Charges	\$ 5,691		
Strike Period Costs	\$ 10,720		
<b>Total Other Administrative and General</b>	\$ 125,272	\$ -	\$ -

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

Name of Facility Senior Philanthropy of Milford O, LLC d/	License No. 2404	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 #
Traditions Senior Management, 24641 US Hwy 19 N, Clearwater, FL, 33763	60,617	Handles all the operations and financial functions directly related to the facility.	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.**

**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
Senior Philanthropy of Milford O, LLC d/b/a West Riv		2404	9/30/2021	18	37
Item	Total	CCNH	RHNS	(Specify)	
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$ 352,640	352,640			
2. Non-Food Supplies	\$ 20,209	20,209			
3. Other (Specify) _____	\$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 89,821	89,821			
c. Other (Specify) _____ Supplies	\$ 2,157	2,157			
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 464,827</b>	<b>464,827</b>			
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?	<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 Senior Philanthropy of Milford O, LLC d/b/a West River		License No. 2404	Report for Year Ended 9/30/2021	Page 19	of 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. \$				
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 ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$	222,452	222,452		
c. Other ( <i>Specify</i> ) Supplies	\$				
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	\$	222,452	222,452		
<b>3E. Laundry Questionnaire</b>					
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
K. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

\* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.  
 All allocations should add to total recorded in 3D.  
 \*\*\* Pounds of Laundry only required for multi-level facilities.

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

Name of Facility		License No.	Report for Year Ended		Page	of
Senior Philanthropy of Milford O, LLC d/b/a W		2404	9/30/2021		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
	a. In-House Care					
	1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$				
	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. \$	69,891	69,891		
	C. Other ( <i>Specify</i> ) Supplies		\$ 2,112	2,112		
4D.	<b>Total Housekeeping Expenditures (4a + b + c)</b>		\$ 72,003	72,003		
5.	Resident Care (Supplies)**					
	a. Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from	\$	303,743	303,743		
	b. Medicine Cabinet Drugs	\$	23,397	23,397		
	c. Medical and Therapeutic Supplies	\$	172,786	172,786		
	d. Ambulance/Limousine***	\$	4,031	4,031		
	e. Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	23,076	23,076		
	f. X-rays and Related Radiological Procedures***	\$	10,147	10,147		
	g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
	h. Laboratory***	\$	488	488		
	i. Recreation	\$	1,407	1,407		
	j. Direct Management Services*	\$				
	k. Indirect Management Services*	\$				
	l. Other (Specify)**** See Attached Schedule	\$	136,434	136,434		
5M.	<b>Total Resident Care Expenditures (5a - 5j)</b>		\$ 675,509	675,509		

\* 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)
Equipment Minor	\$ 12,735		
Minor Equip & Supplies - Therap	\$ 1,868		
IV Supplies-Medicaid	\$ 3,066		
COVID Testing	\$ 7,530		
IV Drugs-Medicare	\$ 17,345		
Equipment Rental	\$ 44,443		
Equipment Minor	\$ 20,464		
IV Drugs-Managed Care	\$ 15,809		
Medical Waste Disposal	\$ 3,262		
Cable	\$ 9,913		
<b>Total Other Resident Care</b>	\$ 136,434	\$ -	\$ -

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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	
Senior Philanthropy of Milford O, LLC d/b/a West River Rehab Center			2404		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
Total Lawn Care & More	15 Clark St., Apt. 1, Milford, CT 06460	<input type="radio"/>	<input checked="" type="radio"/>		Grounds Maintenance	36,742			22	6f
CWPM LLC	25 Norton Place, Plainsville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>		Trash Removal	42,835			22	6f
Rinaldi Linen Service	47 Commons Court., Waterbury, CT 06704	<input type="radio"/>	<input checked="" type="radio"/>		Laundry Services	136,048			19	3b
Healthcare Services Group	300, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		Laundry Services	86,404			19	3b
Healthcare Services Group	300, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		Housekeeping	69,891			20	4b
Healthcare Services Group	300, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		Dietary Services	89,821			18	2b
Healthcare Services Group		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
Senior Philanthropy of Milford O, LLC d/b/a	2404	9/30/2021			22	37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	33,833	33,833			
b. Heat	\$	31,322	31,322			
c. Light & Power	\$	111,012	111,012			
d. Water	\$	24,081	24,081			
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$					
f. Other ( <i>itemize</i> )	\$	172,477	172,477			
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	<b>\$</b>	<b>372,724</b>	<b>372,724</b>			
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$					
b. Building & Building Improvements	\$	23,789	23,789			
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$	86,431	86,431			
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$</b>	<b>110,220</b>	<b>110,220</b>			
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other ( <i>Specify</i> )	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	<b>\$</b>					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	1,019,877	1,019,877			
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	146,687	146,687			
c. Personal property taxes	\$	5,116	5,116			
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$</b>	<b>1,281,900</b>	<b>1,281,900</b>			

\* 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)
Electrical	\$ 2,705		
Plumbing	\$ 9,265		
HVAC/Boiler	\$ 38,713		
Paint	\$ 1,227		
Alarm Inspection-Maint	\$ 734		
Alarm Maintenance & Repairs	\$ 5,290		
Ground Maintenance	\$ 36,742		
Sprinklers	\$ 1,384		
Elevator	\$ 10,295		
Pest Control	\$ 1,925		
Maintenance Contracts	\$ 441		
Equipment Minor	\$ 8,338		
Equipment Rental	\$ 5,872		
Waste Disposal	\$ 42,835		
Copier Maintenance	\$ 6,712		
<b>Total Other Repairs and Maintenance</b>	<b>\$ 172,477</b>	<b>\$ -</b>	<b>\$ -</b>

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### Depreciation Schedule

Name of Facility				License No.			Report for Year Ended			Page	of		
Senior Philanthropy of Milford O, LLC d/b/a West River Rehab Center				2404			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		
<b>A. Land Improvements</b>													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal													
<b>B. Building and Building Improvements</b>													
1. Acquired prior to this report period				342,780		342,780	117,398	S/L	Various	23,789			
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal											23,789		
<b>C. Non-Movable Equipment</b>													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal													
		Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
		Yes	No	Month	Year								
<b>D. Movable Equipment</b>													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a. 2015 Ford Transit 250 - 10 Passengers				5	15	40,257		40,257	40,256	S/L	5		
b. Corporate Fleet - taxable value				5	16	1,110		1,110	1,110	S/L	5		
c. Corporate Fleet - taxable value				4	17	1,693		1,693	1,356	S/L	5	337	
d.													
2. Movable Equipment													
a. Acquired prior to this report period				Var	Var	974,945		974,945	755,541	S/L	Various	81,067	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)						25,146						5,029	
D-3. Subtotal													86,434
<b>E. Total Depreciation</b>												110,223	

Senior Philanthropy of Milford O, LLC d/b/a West River Rehab Center  
9/30/2021

**Schedule of Land Improvements Acquired during this report period**

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

\*Ties to Page 23, Line A3

\*\*Ties to Page 23, Line A2

**Schedule of Building Improvements Acquired during this report period**

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

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

**Schedule of Non-Movable Equipment Acquired during this report period**

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

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2

## Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
6/25/2021	Sump Pump	\$ 11,427	5	\$ 2,285
9/3/2021	7.5 Ton RTU	\$ 13,719	5	\$ 2,744
<b>Total additions for Movable Equipment</b>		\$ 25,146		\$ 5,029 *
<b>Deletions:</b>				
<b>Total deletions for Movable Equipment</b>		\$ -		\$ - **

\*Ties to Page 23, Line D2c

\*\*Ties to Page 23, Line D2b

## Schedule of Leasehold Improvements Acquired during this report period

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

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

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

CSP-24 Rev. 10/2006

**Amortization Schedule\***

Name of Facility			License No.		Report for Year Ended			Page	of
Senior Philanthropy of Milford O, LLC d/b/a West River Rel			2404		9/30/2021			24	37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
<b>D. Total Amortization</b>									

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

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

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

Name of Facility Senior Philanthropy of Milford O, LLC	License No. 2404	Report for Year Ended 9/30/2021	Page 25	of 37	
<b>11. Property Questionnaire</b>					
<b>Part A</b>					
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description	Total				
1. Date Land Purchased					
2. Date Structure Completed					
3. If <b>NOT</b> Original Owner, Date of Purchase					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	120				
6. Square Footage					
7. Acquisition Cost					
a. Land					
b. Building					
<b>Part B - Owner and Related Parties</b>		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)					
b. Date Mortgage Obtained					
c. Interest Rate for the Cost Year					
d. Term of Mortgage (number of years)					
e. Amount of Principal Borrowed					
f. Principal balance outstanding as of					
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>					
g. Type of Financing (e.g., fixed, variable)					
h. Date of Refinancing					
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed					
l. Principal Outstanding on Note Paid-Off					
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	
245 Orange Ave LLC, 245 Orange Ave., Milford, CT 06461	Building	04/01/15	123 mos.	959,053	

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Senior Philanthropy of Milford O, LL	2404	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. <b>Total Building Interest Expense</b> (A1 - A4 + B5)	\$			

*(Carry Subtotals forward to next page)*

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

Name of Facility	License No.	Report for Year Ended	Page	of
Senior Philanthropy of Milford O,	2404	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)	\$	19,902	19,902	
13. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>	\$	19,902	19,902	
14. Insurance				
a. Insurance on Property (buildings only)	\$	26,030	26,030	
b. Insurance on Automobiles	\$	4,625	4,625	
c. Insurance other than Property (as specified above)				
1. Umbrella (Blanket Coverage)	\$	62,308	62,308	
2. Fire and Extended Coverage	\$			
3. Other (Specify)	\$			
14d. <b>Total Insurance Expenditures (14a + b + c)</b>	\$	92,963	92,963	
15. <b>Total All Expenditures (A-13 thru C-14)</b>	\$	13,352,138	13,352,138	



### D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Senior Philanthropy of Milford O, LLC d/b/a West River Rehal				2404	9/30/2021	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
<b>Page 13 - Professional Fees</b>							
5.	13	B8c	Resident Care Physicians **	\$ (15,189)	(15,189)		
6.	13	10a	Occupational Therapy	\$ 482,352	482,352		
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 726,090	726,090		
10.			Accounting	\$			
10a.			Legal	\$ 1,813	1,813		
11.			Telephone	\$			
12.			Cellular Telephone	\$			
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.			Automobile Expense (e.g. personal use)	\$			
18.	16	m3	Unallowable Advertising *	\$ (125)	(125)		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.	16	m12	Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 12,683	12,683		
<b>Page 18 - Dietary Expenditures</b>							
24.	30	IV1	Meals to employees, guests and others who are not residents	\$			
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 1,207,624	1,207,624		

\* 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)
<b>Total Other Salaries Adjustment</b>			\$ -	\$ -	\$ -

**Schedule of Fees Adjustments**

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

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Res Reimburse Lost/Stolen Items	\$ 3,407		
16	m13	Collection Fees/Credit Card Fee	\$ 1,840		
16	m13	Late fees/Fines/Finance Charges	\$ 7,436		
<b>Total Other A&amp;G Adjustments</b>			\$ 12,683	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
Senior Philanthropy of Milford O, LLC d/b/a West River Rel				2404	9/30/2021	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,207,624	1,207,624		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5a2	Prescription Drugs	\$ 303,743	303,743		
28.	20	5d	Ambulance/Limousine	\$ 4,031	4,031		
29.	20	5f	X-rays, etc	\$ 10,147	10,147		
30.	20	5h	Laboratory	\$ 488	488		
31.			Medical Supplies	\$			
32.	20	5e2	Oxygen (non emergency)	\$ 23,076	23,076		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 36,220	36,220		
<b>Page 22 - Maintenance and Property</b>							
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	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 1,585,329	1,585,329		

\*\*\* 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.

Senior Philanthropy of Milford O, LLC d/b/a West River Rehab Center  
 9/30/2021

**Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
	20/5j	IV Supplies-Medicaid	\$ 3,066		
	20/5j	IV Drugs-Medicare	\$ 17,345		
	20/5j	IV Drugs-Managed Care	\$ 15,809		
<b>Total Other Ancillary Costs</b>			\$ 36,220	\$ -	\$ -

**Schedule of Excess Movable Equipment Depreciation**

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

**Schedule of Other Property Adjustments**

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

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Adjustments</b>			\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

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

## Annual Report of Long-Term Care Facility

CSP-30 Rev.10/2005

## F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Senior Philanthropy of Milford O, LLC	d/2404	9/30/2021		30	37
Item	Total	CCNH	RHNS	(Specify)	
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 10,793,037	10,793,037			
b. Medicaid Room and Board Contractual Allowance **	\$ (4,947,829)	(4,947,829)			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 3,709,473	3,709,473			
b. Medicare Room and Board Contractual Allowance **	\$ 1,269,381	1,269,381			
4. a. Private-Pay Residents and Other	\$ 3,658,344	3,658,344			
b. Private-Pay Room and Board Contractual Allowance **	\$ (605,343)	(605,343)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 269,853	269,853			
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$ 163,709	163,709			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$				
2. a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$ 1,075,840	1,075,840			
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$ 744,080	744,080			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$ 214,800	214,800			
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$ 146,475	146,475			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$ 1,318,440	1,318,440			
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$ 881,560	881,560			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other ( <i>Specify</i> ) - Medicare	\$ (2,617,064)	(2,617,064)			
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ (1,767,421)	(1,767,421)			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 14,307,335	14,307,335			
<b>IV. Other Revenue*</b>					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income ( <i>Specify</i> )	\$ 1,364	1,364			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 1,705,798	1,705,798			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 1,707,162	1,707,162			
<b>VI. Total All Revenue</b> (III +V)	\$ 16,014,497	16,014,497			

\* 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/II6a	Laboratory	\$ 34,046		
30/II6a	IV Therapy	\$ 18,477		
30/II6a	X-Ray	\$ 21,533		
30/II6a	Contract Adj-Ancillary	\$ (2,301,890)		
30/II6a	Flu Shots - MCR B - SNF	\$ 3,430		
30/II6a	Contract Adj-Ancillary	\$ (392,660)		
<b>Total Other Resident Revenue - Medicare</b>		\$ (2,617,064)	\$ -	\$ -

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

**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
30/II6b	Laboratory	\$ 32,416		
30/II6b	IV Therapy	\$ 23,457		
30/II6b	X-Ray	\$ 16,602		
30/II6b	Prior Yr-Contract Adj	\$ 121,561		
30/II6b	Contract Adj-Ancillary	\$ (1,913,245)		
30/II6b	Contract Adj-Room	\$ (31,746)		
30/II6b	Sequestration	\$ (16,466)		
<b>Total Other Resident Revenue</b>		\$ (1,767,421)	\$ -	\$ -

**Interest Income**

**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30?IV5	Interest Income		\$ 1,364		
<b>Total Interest Income</b>			\$ 1,364	\$ -	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
30/IV8	COVID Relief Income	\$ 1,705,798		
<b>Total Other Revenue</b>		\$ 1,705,798	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Senior Philanthropy of Milford O, LLC	2404	9/30/2021	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	437,357
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,393,184
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	60,986
a. _____				
b. _____				
c. _____				
d. See Schedule		60,986		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	5,085,654
_____				
_____				
See Schedule		5,085,654		
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	7,977,181
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost <u>342,780</u>		\$	201,593
	Accum. Depreciation <u>141,187</u>	Net		
4. Leasehold Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>1,000,090</u>		\$	158,453
	Accum. Depreciation <u>841,637</u>	Net		
7. Motor Vehicles	*Historical Cost <u>43,060</u>		\$	
	Accum. Depreciation <u>43,060</u>	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	(70,716)
_____				
See Schedule		(70,716)		
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	289,330

\* 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 Senior Philanthropy of Milford O, LLC	License No. 2404	Report for Year Ended 9/30/2021	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	8,266,512
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements		*Historical Cost _____ Accum. Depreciation _____ Net	\$	
3. Buildings		*Historical Cost _____ Accum. Depreciation _____ Net	\$	
4. Non-Movable Equipment		*Historical Cost _____ Accum. Depreciation _____ Net	\$	
5. Movable Equipment		*Historical Cost _____ Accum. Depreciation _____ Net	\$	
6. Motor Vehicles		*Historical Cost _____ Accum. Depreciation _____ Net	\$	
7. Minor Equipment-Not Depreciable			\$	
C-8 <b>Total Leasehold or Like Properties</b> (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	913,409
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> )			\$	
See Schedule			\$	
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	913,409
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$	9,179,920

\* 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
Senior Philanthropy of Milford O, LLC d/b/a	2404	9/30/2021	33	37
Account				Amount
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable				\$ 767,059
2. Notes Payable ( <i>itemize</i> )				\$
_____				
_____				
See Schedule				
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$ 194,905
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$
6. Accrued Payroll Taxes Payable				\$ 55,487
7. Medicare Final Settlement Payable				\$
8. Medicare Current Financing Payable				\$
9. Mortgage Payable ( <i>Current Portion</i> )				\$
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )				\$
11. Accrued Income Taxes*				\$
12. Other Current Liabilities ( <i>itemize</i> )				\$ 2,697,022
_____				
_____				
See Schedule 2,697,022				
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>				<b>\$ 3,714,473</b>

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

(Carry Total forward to next page)

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

Name of Facility Senior Philanthropy of Milford O, LLC d/b/	License No. 2404	Report for Year Ended 9/30/2021	Page 34	of 37
Account				Amount
Total Brought Forward:				3,714,473
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> )				
				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$ 15,922
_____				
_____				
See Schedule				15,922
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 15,922
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 3,730,396

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

Name of Facility	License No.	Report for Year Ended	Page	of
Senior Philanthropy of Milford O, LLC	2404	9/30/2021	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
<b>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	2,873,262
6. Gain or Loss for Period			\$	2,662,358
	10/1/2020	thru 9/30/2021		
7. Total Net Worth			\$	5,535,620
<b>C. Total Reserves and Net Worth</b>			\$	5,535,620
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	9,266,016

### H. Changes in Total Net Worth

Name of Facility Senior Philanthropy of Milford O, LLC d	License No. 2404	Report for Year Ended 9/30/2021	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2020			\$	1,847,411
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$	16,014,497
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$	13,352,138
D. Net Income or Deficit			\$	2,662,358
E. Balance			\$	4,509,769
F. Additions				
1. Additional Capital Contributed ( <i>itemize</i> )				
2. Other ( <i>itemize</i> )				
F-3. Total Additions				
G. Deductions				
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )			\$	
Name and Address ( <i>No., City, State, Zip</i> )		Title	Amount	
2. Other Withdrawings ( <i>Specify</i> )			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. <b>Balance at End of Period</b>			\$	4,509,769

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

Name of Facility Senior Philanthropy of Milford O, LLC	License No. 2404	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)		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
CJLC LLC				
Address Address			Phone Number	
225 Pitkin Street, East Hartford, CT 06108			860-610-9009	
Annual Report Contact			Phone Number	
CJLC			860-610-9009	
Annual Report Contact Email Address				
annualreports@cjlc.com				