State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2025

Name of Facility (as licensed) Robert C. Geer Memorial Hospital, Inc. d/b/a Geer Nursing and Rehabilitation Center		
Address (No. & Street, City, State, Zip Code) 99 South Canaan Road, Canaan, CT 06018		
Type of Facility ☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined	☐ (Specify)	☐ (Specify)
Report for Year Beginning 10/1/2024	Report for Year Ending 9/30/2025	

License Numbers:	CCNH / RHNS 843-C	(Specify)	(Specify)	Medicare Provider 07-5202

Medicaid Provider Numbers:	CCNH / RHNS 000008433	(Specify)	(Specify)

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Robert C. Geer Memorial Hospital, Inc. d/b/a Geer Nurs	843-C	9/30/2025	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 Robert C. Geer Memorial Hospital, Inc. d/b/a Geer Nursing and Rehabilitation Center [facility name], for the cost report period beginning October 1, 2024 and ending September 30, 2025, and that to the best of my knowledge and belief, it is a true, correct, and complete statemer 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. (a)

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.

(a) Subject to Desk Audit Review

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Dan Rupenski			Printed Name (Owner) Shaun Powell	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Robert C. Geer Memorial Hospital, Inc. d/b/a Geer Nursing and Rehabilitation Center	Period Covered:		From 10/1/2024	To 9/30/2025
Address of Facility 99 South Canaan Road, Canaan, CT 06018				
Report Prepared By Baker Tilly Advisory Group, LP	Phone Number 203-366-5876		Date 2/12/2026	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-824-5137	9/30/2025	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Robert C. Geer Memorial Hospital, Inc. d/b/a Geer Nursing and R	99 South Canaan Road, Canaan, CT 06018

License Numbers:	CCNH / RHNS	(Specify)	(Specify)	Medicare Provider No.
	843-C			07-5202

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined ☐ (Specify) ☐ (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.:	
Dan Rupenski		2118

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

Name	License No.:
N/A	

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Robert C. Geer Memorial Hospital, Inc. d/b/a Geer Nu	843-C	9/30/2025	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
N/A		

Name of Partners/Members	Business Address	Title	% Owned
N/A			

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Robert C. Geer Memorial Hospital, Inc. d/b/a	843-C	9/30/2025	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
Robert T. Geer Memorial Hospital, Inc. d/b/a Geer Nursing and Rehabilitation	99 South Canaan Road, Canaan, CT 06018	CT

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

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Robert C. Geer Memorial Hospital, Inc. d/b/a Geer	843-C	9/30/2025	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
Robert C. Geer Memorial Hospital, Inc. d/b/a Geer Nur	843-C	9/30/2025	4	37

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	%**				
Geer Corporation	99 South Canaan Road, North Canaan, CT	○	⊙		Management Services	Page 16 / M12	608,250	608,250
Conquest Consulting	30 Tower Lane, 4th Floor, Avon, CT	○	⊙		Internet Marketing Consultant	Page 16 / M11	18,000	18,000
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

* 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.

Note that due to accounting changes the cost report was prepared with only nursing facility related expenses. This resulted in no ADH or transportation expenses being reported within the cost report.

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

N/A

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

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

N/A

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General Information and Questionnaire
Other Lines of Business

Name of Facility	License No.	Report for Year Ended	Page	of
Robert C. Geer Memorial Hospital, In	843-C	9/30/2025	6	37

Square footage of entire facility.	57,840

Outpatient Therapy

Does the Facility provide outpatient therapy services?	Yes

If yes, please complete the following:

1,460	Square footage of therapy space.

Meals on Wheels

Does the facility provide Meals on Wheels?	No

If yes, please complete the following:

	Square footage of kitchen	
	Number of meals served per week	
No	Are meals included in meals served on page 18 of the Annual Report?	
No	Are direct costs included in the Annual Report?	
	If yes, please state where costs are reported.	
No	Are drivers for the program included in the facility's payroll?	
	If yes, please complete the following:	
		Amount Reported
		Annual Report page and line
	Please state the salary amounts of specific cooks and/or dietary aides	
	Please state where the cooks and/or dietary aides are reported in the Annual Report	

Apartments, Independent Living, Assisted Living

Does the facility have apartments, independent living, and/or assisted living?	No

If yes, please complete the following:

	Square footage of apartments
	Square footage of independent living
	Square footage of assisted living
	Please identify the services provided:

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General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility	License No.	Report for Year Ended	Page	of
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Child Day Care

Does the Facility provide Child Day Care?	No

If yes, please complete the following:

	Square footage of child day care space.
	Average number of daily participants.
	Number of meals per day provided to child day care.
	Nature of services provided:

Adult Day Care

Does the Facility provide Adult Day Care?	No

If yes, please complete the following:

	Square footage of adult day care space.
	Please state where it is located in relation to the facility.
	Average number of daily participants.
	Number of meals per day provided to adult day care.
	Nature of services provided:

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Robert C. Geer Memorial Hospital, Inc. d/b/a Geer Nursing and Rehabili	843-C	9/30/2025	8	37

	Total All Levels	Total CCNH / RHNS Level	Total (Specify)	Total (Specify)	Period 10/1 Thru 6/30 Total	Period 10/1 Thru 6/30 CCNH / RHNS	Period 10/1 Thru 6/30 (Specify)	Period 10/1 Thru 6/30 (Specify)	Period 7/1 Thru 9/30 Total	Period 7/1 Thru 9/30 CCNH / RHNS	Period 7/1 Thru 9/30 (Specify)	Period 7/1 Thru 9/30 (Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	120	120			120	120						
B. On last day of THIS report period	120	120							120	120		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	79	79			79	79						
B. As of midnight of THIS report period	82	82							82	82		
3. Total Number of Days Care Provided During Period												
A. Medicare	2,049	2,049			1,440	1,440			609	609		
B. Medicaid (Conn.)	17,210	17,210			12,616	12,616			4,594	4,594		
C. Medicaid (other states)	365	365			273	273			92	92		
D. Private Pay	7,195	7,195			5,643	5,643			1,552	1,552		
E. State SSI for RCH												
F. Other (Specify) Other Managed Care	1,513	1,513			1,089	1,089			424	424		
G. Total Care Days During Period (3A thru F)	28,332	28,332			21,061	21,061			7,271	7,271		
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. ***Total Resident Days*** **(3G + 4A + 4B)**	28,332	28,332			21,061	21,061			7,271	7,271		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH / RHNS	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	(Specify)	R.C.H.	ICF-MR
No. of Residents	8	49		25				
Per Diem Rate								
a. One bed rm.	Various	326.58		580.00				
b. Two bed rms.	Various	326.58		520.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B	13,712	13,712			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	1,286	1,286			
2. Restorative Treatments					
C. Other	27,853	27,628		225	
D. ***Total Physical Therapy Treatments***	42,851	42,626		225	
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	6,062	6,062			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	568	568			
2. Restorative Treatments					
C. Other	12,314	12,314			
D. ***Total Speech Therapy Treatments***	18,944	18,944			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	24,347	24,347			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	1,699	1,699			
2. Restorative Treatments					
C. Other	30,576	26,149		4,427	
D. ***Total Occupational Therapy Treatments***	56,622	52,195		4,427	

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Robert C. Geer Memorial Hospital, Inc. d/b/a Geer Nursing ar	843-C	9/30/2025	10	37

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

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
A. Salaries and Wages*									
1. Operators/Owners (Complete also Sec. I of Schedule A1)									
2. Administrator(s) (Complete also Sec. III of Schedule A1)	100,275		2,080						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)									
5. Dietary Service									
a. Head Dietitian									
b. Food Service Supervisor									
c. Dietary Workers	465,552		23,626						
6. Housekeeping Service									
a. Head Housekeeper									
b. Other Housekeeping Workers	187,308		10,422						
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance									
b. Other Maintenance Workers	194,891	(4,634)	8,413						
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	139,448		2,080						
b. RN									
1. Direct Care	916,913		16,798						
2. Administrative**	331,439		7,918						
c. LPN									
1. Direct Care	1,049,560		27,554						
2. Administrative**									
d. Aides and Attendants	2,269,615		97,800						
e. Physical Therapists									
f. Speech Therapists									
g. Occupational Therapists									
h. Recreation Workers	95,397		4,632						
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	97,286		2,679						
n. Marketing									
o. Other (Specify)									
See Attached Schedule	236,156	(156,848)	6,840						
A-13. Total Salary Expenditures	6,083,840	(161,482)	210,842						

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.
** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.
*** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed in the Adjustment column.

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH / RHNS $	CCNH / RHNS Adjustment	CCNH / RHNS Hours	(Specify) $	(Specify) Adjustment	(Specify) Hours	(Specify) $	(Specify) Adjustment	(Specify) Hours
	-								
Outpatient Rehab	$ 156,848	$ (156,848)	2,210						
Medical Records	$ 21,891		3,323						
Admissions	$ 57,417		1,307						
Total	$ 236,156	$ (156,848)	6,840	$ -	$ -	-	$ -	$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH / RHNS $	CCNH / RHNS Adjustment	CCNH / RHNS Hours	(Specify) $	(Specify) Adjustment	(Specify) Hours	(Specify) $	(Specify) Adjustment	(Specify) Hours
	-								
Total	$ -	$ -	-	$ -	$ -	-	$ -	$ -	-

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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)	(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
Robert C. Geer Memorial Hospital, Inc. d/b/a Geer Nursing and Rehab	843-C	9/30/2025	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	(Specify)	(Specify)							
Section III - Administrators* **										
Dan Rupenskui (10/1/2024-9/30/2025)	100,275			Non-Discriminatory	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
Robert C. Geer Memorial Hospital, Inc. d/b/a Geer M	843-C	9/30/2025	13	37

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)									
1. Dietitian	49,990		1,035						
2. Dentist	16,290		109						
3. Pharmacist	12,224		81						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	194,774		2,435						
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	32,560		130						
b. Utilization Review (Title 18 and 19 only) monthly meeting									
c. Resident Care**									
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	86,109		861						
b. Other									
10. Occupational Therapist									
a. Resident Care	257,371	(257,371)	3,217						
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care									
2. Administrative***									
b. LPN									
1. Direct Care									
2. Administrative***									
c. Aides									
d. Other									
12. Other (Specify) See Attached Schedule									
B-13 Total Fees Paid in Lieu of Salaries	649,318	(257,371)	7,868						

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

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

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

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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
Robert C. Geer Memorial Hospital, Inc. d/b/a Geer Nurs	843-C	9/30/2025	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Laura W. Koski, Rd, 399 Washington Rd, Terryville, CT 06786	Dietician	○	⊙	N/A
HDC Care Solutions, LLC, 100 Crossing Blvd. Suite 300, Framingham, MA 01702	Dentist	○	⊙	N/A
HDC Care Solutions, LLC, 100 Crossing Blvd. Suite 300, Framingham, MA 01702	Medical Director	○	⊙	N/A
HHCMG Specialists, PO Box 412744, Boston, MA 02241	Medical Director	○	⊙	N/A
Hancock LTC, Inc., 840 East Main St., Ste B, Meriden, CT 06450	Pharmacist	○	⊙	N/A
Preferred Therapy Solutions; 850 Silas Deane Hwy, 2nd Floor, Wethersfield, CT 06109	PT, ST, OT	○	⊙	N/A
		○	⊙	
		○	⊙	
		○	⊙	
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* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended					Page	of
Robert C. Geer Memorial Hospital, Inc. d/b/a Ge	843-C	9/30/2025					15	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	$	150,226	154,323	(4,097)				
2. Disability Insurance	$	29,020	29,812	(792)				
3. Unemployment Insurance	$	9,405	9,661	(256)				
4. Social Security (F.I.C.A.)	$	458,288	470,784	(12,496)				
5. Health Insurance	$	609,064	625,673	(16,609)				
6. Life Insurance (employees only) (not-owners and not-operators)	$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$							
8. Uniform Allowance	$							
9. Other (*Specify*) See Attached Schedule	$	10,919	10,919					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$							
c. Bad Debts*	$		360,000	(360,000)				
d. Accounting and Auditing	$	24,880	24,880					
e. Legal (*Services should be fully described on Page 15b)*	$	1,860	2,210	(350)				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$							
g. Office Supplies	$	7,923	7,923					
h. Telephone and Cellular Phones								
1. Telephone & Pagers	$	40,532	40,532					
2. Cellular Phones	$	2,270	2,270					
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*	$							
2. Other (*Specify*) See Attached Schedule	$							
3. Resident Day User Fee	$	551,859	551,859					
Subtotal	$	1,896,246	2,290,846	(394,600)				

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
	-					
EMPLOYEE TESTS - TB, OSHA, ETC	$ 1,312					
403b Employer Match	$ 9,607					
Total	$ 10,919	$ -	$ -	$ -	$ -	$ -

Schedule of Other Taxes

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

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Robert C. Geer Memorial Hospital,	843-C	9/30/2025	15b	37

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 Baker Tilly Advisory Group, LP	50 Fremont Street Suite 4000 San Francisco, CA 94105
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Accounting, Audit and Cost Report Preparation	$ 24,880
2		$
3		$
4		$
		Charge for Services Provided $ 24,880

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 Marshall Ed Rice	860-713-5372
2 Treasurer, State of CT	860-702-3000
3 Kainen, Escalera & Michale	860-493-0870
4	
5	

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

1 450 Columbus Boulevard, Suite 1403 Hartford, Connecticut 06103
2 165 Capitol Ave, Hartford, CT 06106
3 21 Oak St, Hartford, CT 06106
4
5

Services Provided by This Firm (*describe fully*)

1	Probate Services (Disallowed)	$ 100
2	Probate Services (Disallowed)	$ 250
3	Employee Matters	$ 1,860
4		$
5		$
		Charge for Services Provided $ 2,210

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

Name of Facility	License No.	Report for Year Ended					Page	of
Robert C. Geer Memorial Hospital, Inc. d/b/a Geer Nu	843-C	9/30/2025					16	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:		1,896,246	2,290,846	(394,600)				
l. Travel and Entertainment								
1. Resident Travel and Entertainment	$		36,000	(36,000)				
2. Holiday Parties for Staff	$	2,117	2,117					
3. Gifts to Staff and Residents	$							
4. Employee Travel	$	336	336					
5. Education Expenses Related to Seminars and Conventions	$	3,600	3,600					
6. Automobile Expense (*not purchase or depreciation*)	$	1,531	1,531					
7. Other (*Specify*)	$							
See Attached Schedule								
m. Other Administrative and General Expenses								
1. Advertising Help Wanted (*all such expenses*)	$	25,638	25,638					
2. Advertising Telephone Directory (*all such expenses*)***	$							
3. Advertising Other (*Specify*)***	$							
See Attached Schedule								
4. Fund-Raising***	$							
5. Medical Records	$	75	75					
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$		11,299	(11,299)				
7. Postage	$	8,655	8,655					
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$							
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$							
9. Subscriptions	$	18,166	18,166					
10. Contributions***	$		137	(137)				
See Attached Schedule								
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	204,816	222,816	(18,000)				
12. Administrative Management Services**	$	608,250	608,250					
13. Other (*Specify*)	$	(23,311)	28,507	(51,818)				
See Attached Schedule								
C-14 Total Administrative & General Expenditures	$	2,746,119	3,257,973	(511,854)				

* 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 expensein the Adjustment column.

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
	-					
Total Other Advertising	$ -	$ -	$ -	$ -	$ -	$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
	-					
Total Dues	$ -	$ -	$ -	$ -	$ -	$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
	-					
DONATIONS/MAKE A WISH	$ 137	$ (137)				
Total Contributions	$ 137	$ (137)	$ -	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
	-					
Outside Svcs Computer-Datahal	$ 479					
PERMITS	$ 300					
EMPLOYEE RECOGNITION	$ 4,081	$ (4,081)				
BANK FEES	$ 324					
FINANCE CHARGES	$ 23,323	$ (23,323)				
ADMINISTRATIVE INCOME (Disallowed from Page 30 Line IV 8)		$ (24,414)				
Total Other Administrative and General	$ 28,507	$ (51,818)	$ -	$ -	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Robert C. Geer Memorial Hospital, Inc. d/	843-C	9/30/2025	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 #
Geer Corporation-Canaan CT	608,250	Mgmt of Facility, HR, Maintenance, AP, AR, & Benefits	Page 16/ Line 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
Robert C. Geer Memorial Hospital, Inc. d/b/a Geer Nursi	843-C	9/30/2025					18	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	$	307,150	307,467	(317)				
2. Non-Food Supplies	$	63	63					
3. Other (*Specify*)_____	$							
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	261,078	261,078					
c. Other (*Specify*)_____	$							
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	568,291	568,608	(317)				

		Total	CCNH / RHNS	(Specify)	(Specify)
2E.	Dietary Questionnaire				
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.	317
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				Pg 30 Line IV1

* 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
Robert C. Geer Memorial Hospital, Inc. d/b/a Geer Nurs	843-C	9/30/2025	19	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
3. Laundry								
a. In-House Processing*								
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.							
	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 (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	73,877	73,877					
c. Other (*Specify*) Laundry Supplies	$	4,121	4,121					
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	77,998	77,998					

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

Name of Facility	License No.	Report for Year Ended					Page	of
Robert C. Geer Memorial Hospital, Inc. d/b/a G	843-C	9/30/2025					20	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4. Housekeeping	Sq. Ft. Serviced by Personnel							
a. In-House Care								
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt. $	25,279	25,279					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel							
	Amt. $							
C. Other (*Specify*)	$							
4D. ***Total Housekeeping Expenditures*** (4a + b + c)	$	25,279	25,279					
5. Resident Care (Supplies)**								
a. Prescription Drugs***								
1. Own Pharmacy	$		183,496	(183,496)				
2. Purchased from	$							
b. Medicine Cabinet Drugs	$	119,414	119,414					
c. Medical and Therapeutic Supplies	$	24,159	26,204	(2,045)				
d. Ambulance/Limousine***	$							
e. Oxygen								
1. For Emergency Use	$							
2. Other***	$		45,768	(45,768)				
f. X-rays and Related Radiological Procedures***	$							
g. Dental (*Not dentists who should be included under salaries or fees)*	$							
h. Laboratory***	$							
i. Recreation	$	13,759	13,759					
j. Direct Management Services*	$							
k. Indirect Management Services*	$							
l. Cable TV	$	7,200	54,376	(47,176)				
m. Other (Specify)**** See Attached Schedule	$	13,924	102,234	(88,310)				
n. Physical Therapy Expense	$							
o. Speech Therapy Expense	$							
5P. ***Total Resident Care Expenditures*** (5a - 5o)	$	178,456	545,251	(366,795)				

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

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

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

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

Schedule of Other Resident Care

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
	-					
PATIENT SUPPLIES - REHAB	$ 1,159	$ (532)				
Lost Resident Items	$ 4,871	$ (4,871)				
MEDICARE ADD-ON EXPENSES	$ 47,928	$ (47,928)				
IN PAT SUPPLIES - ST	$ 13,297					
OUTPATIENT SUPPLIES	$ 307	$ (307)				
OUTPAT - DUES & SUBSCRIPTIONS	$ 27,837	$ (27,837)				
OUTPATIENT WEBPT SOFTWARE COST	$ 6,600	$ (6,600)				
OUT-PAT THER SUPPLY/BILLABLE	$ 215	$ (215)				
OUT PAT THERAPY SUPPLIES/GENE	$ 20	$ (20)				
Total Other Resident Care	$ 102,234	$ (88,310)	$ -	$ -	$ -	$ -

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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
Robert C. Geer Memorial Hospital, Inc. d/b/a Geer Nursing and Rehabilitati	843-C	9/30/2025	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH / RHNS	(Specify)	(Specify)	Pg	Line
Kone Brooklyn	PO Box 22251, New York, NY 10087-2251	○	⊙	N/A	Elevator Services	28,641			22	6f
PointClickCare Technologies Inc.	PO Box 674802, Detroit, MI 48267-4802	○	⊙	N/A	Software Services	45,056			16	m11
Unitex Textile Rental Services	Pkwy, Mount Vernon, NY 10550-1700	○	⊙	N/A	Laundry	72,006			19	3b
USA Waste and Recycling, Inc.	PO Box 1000, East Windsor, CT 06088	○	⊙	N/A	Trash Removal	41,039			22	6f
Datahal, LLC	730 Hayden Hill Road, Torrington, CT 06790	○	⊙	N/A	IT Support	59,400			16	m11
Conquest	PO Box 416, Avon, CT 06001	⊙	○	Affiliate	Internet Marketing Consultant	18,000			16	m11
Unidine Corporation	PO Box 102289, Atlanta, GA 30368	○	⊙	N/A	Food Services	261,078			18	2b
Paycom	Oklahoma City, OK 73142	○	⊙	N/A	Payroll Services	62,431			16	m11
Geer Corporation	99 South Canaan Road, North Canaan, CT	⊙	○	Affiliate	Management Services	608,250			16	m12
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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	of
Robert C. Geer Memorial Hospital, Inc. d/b/a G	843-C	9/30/2025	22	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	$	13,173	13,188	(15)				
b. Heat	$	83,119	83,213	(94)				
c. Light & Power	$	103,817	103,935	(118)				
d. Water	$	28,477	28,509	(32)				
e. Equipment Lease (*Provide detail on page 22b*)	$	31,084	31,084					
f. Other (*itemize*)	$	148,507	148,507					
See Attached Schedule								
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	408,177	408,436	(259)				
7. Depreciation (*complete schedule page 23**)								
a. Land Improvements	$	2,524	2,524					
b. Building & Building Improvements	$	68,740	68,809	(69)				
c. Non-Movable Equipment	$	8,225	8,225					
d. Movable Equipment	$	48,279	48,279					
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	127,768	127,837	(69)				
8. Amortization (*Complete att. Schedule Page 24**)								
a. Organization Expense	$							
b. Mortgage Expense	$		344	(344)				
c. Leasehold Improvements	$							
d. Other (*Specify*)	$							
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$		344	(344)				
9. Rental payments on leased real property less real estate taxes included in item 10b	$							
10. Property Taxes								
a. Real estate taxes paid by owner	$							
b. Real estate taxes paid by lessor	$							
c. Personal property taxes	$							
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	127,768	128,181	(413)				

* Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 2

Schedule of Other Repairs and Maintenance

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
	-					
CONTRACT MAINT SERVICES	$ 10,279					
O/S Plum,Heat, Refrig	$ 2,841					
O/S Elevators	$ 24,718					
O/S State Required	$ 24,502					
O/S Miscellaneous	$ 4,640					
TRASH REMOVAL	$ 41,039					
Supplies-State Required	$ 1,220					
Supplies-Miscellaneous	$ 6,421					
LANDSCAPING/SNOW REMOVAL	$ 621					
Landscaping	$ 149					
Snow Removal	$ 2,833					
INTERNET SERVICES	$ 29,244					
Total Other Repairs and Maintenance	$ 148,507	$ -	$ -	$ -	$ -	$ -

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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
Robert C. Geer Memorial Hospital, Inc. d/b/a Geer Nursing	843-C	9/30/2025	22b	37

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
Konica Minolta, 21146 Network Place, Chicago, IL 60673	○	⊙	Various Copiers	Various	Various	30,969	30,969
Pitney Bowes Global Financial Services LLC, PO Box 981022, Boston, MA 02298-1022	○	⊙	Postage Machine	10/16/20	Month to Month	115	115
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ⊙ Yes ○ No **Total** *** 31,084

* 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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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Robert C. Geer Memorial Hospital, Inc. d/b/a Geer Nursing and Rehabili	843-C	9/30/2025	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	144,976		144,976	141,054	S/L	Various	2,524	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								2,524
B. **Building and Building Improvements**								
1. Acquired prior to this report period	3,129,858		3,129,858	2,584,568	S/L	Various	65,809	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	144,003		144,003		S/L	Various	3,000	
B-4. Subtotal								68,809
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	80,118		80,118	32,048	S/L	Various	8,012	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	6,285		6,285		S/L	Various	213	
C-4. Subtotal								8,225

	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. Vehicles - Added Prior to 2011			Var	Var	25,884		25,884	25,884	S/L	4		
b. ADC Vehicle / Repairs			6	7	18,624		18,624	18,624	S/L	4		
c. 2010 Truck			10	2016	14,500		14,500	14,500	S/L	4		
d. 2003 Ford 550			7	2019	3,140		3,140	3,140	S/L	4		
2. Movable Equipment												
a. Acquired prior to this report period			Var	Var	876,798		876,798	790,182	S/L	Various	48,279	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative												
d. Standard Resident												
e. Specialized Resident												
Total Acquired during this report period												
D-3. Subtotal												48,279
E. ***Total Depreciation***												127,837

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:					
7/1/2025	Elevator Repairs	$ 144,003	20	$ 3,000	
Total additions for Building Improvements		$ 144,003		$ 3,000	*
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 perio

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
5/1/2025	Water Heater	$ 2,210	10	$ 111	
5/1/2025	Plumbing repairs for Install	$ 4,075	20	$ 102	
Total additions for Non-Movable Equipmen		$ 6,285		$ 213	*
Deletions:					
Total deletions for Non-Movable Equipmen		$ -		$ -	**

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

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

Schedule of Movable Equipment Acquired during this report perio

Acquisition Date	Description of Item	Pick One Movable Category	Cost	Useful Life	Depreciation	
Additions:						
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
Total additions for Movable Equipmen			$ -		$ -	*
Deletions:						
Total deletions for Movable Equipmen			$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report perio

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

***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
Robert C. Geer Memorial Hospital, Inc. d/b/a Geer Nursing a	843-C	9/30/2025	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. Mortgage Expense	Var	Var	Various	91,230	46,693	S/L		344	
2.									
3.									
B-4. Subtotal									344
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***									344

* 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
Robert C. Geer Memorial Hospital, Inc	843-C	9/30/2025	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	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	120
6. Square Footage	
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)	Fixed			
b. Date Mortgage Obtained	01/28/21			
c. Interest Rate for the Cost Year	2.88%			
d. Term of Mortgage (number of years)	35			
e. Amount of Principal Borrowed	21,946,000			
f. Principal balance outstanding as of 9/30/2025	2,013,091	***		
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.
***** 09/30/2025 balance outstanding only includes amount for Geer Nursing.**

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

Name of Facility	License No.	Report for Year Ended	Page	of
Robert C. Geer Memorial Hospital, Inc	843-C	9/30/2025	26	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
12. Interest								
A. Building, Land Improvement & Non-Movable Equipment								
1. First Mortgage	$	59146	59,146					
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)	$	59,146	59,146					

(*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
Robert C. Geer Memorial Hospital,	843-C	9/30/2025	27	37

Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:	59,146	59,146					
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*) $							
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	59,146	59,146					
14. Insurance							
a. Insurance on Property (buildings only) $	123,161	123,284	(123)				
b. Insurance on Automobiles $	4,152	4,152					
c. Insurance other than Property (as specified above)							
1. Umbrella (*Blanket Coverage*) $							
2. Fire and Extended Coverage $							
3. Other (*Specify*) $	28,656	28,656					
D&O Insurance							
14d. ***Total Insurance Expenditures (14a + b + c)*** $	155,969	156,092	(123)				
15. ***Total All Expenditures (A-13 thru C-14)*** $	10,661,508	11,960,122	(1,298,614)				

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Robert C. Geer Memorial Hospital, Inc. d/b/a	843-C	9/30/2025	30	37

Item		Total	CCNH / RHNS	(Specify)	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	8,631,584	8,631,584		
b. Medicaid Room and Board Contractual Allowance **	$	(3,126,138)	(3,126,138)		
2. a. Medicaid (*All other states*)	$	102,740	102,740		
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,065,153	1,065,153		
b. Medicare Room and Board Contractual Allowance **	$	(167,121)	(167,121)		
4. a. Private-Pay Residents and Other	$	4,759,463	4,759,463		
b. Private-Pay Room and Board Contractual Allowance **	$	(582,169)	(582,169)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	84,610	84,610		
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$	84,803	84,803		
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	$	213,815	213,815		
b. Physical Therapy - Medicare Contractual Allowance **	$				
c. Physical Therapy - Non-Medicare	$	232,265	232,265		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	160,330	160,330		
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$	58,150	58,150		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	395,550	395,550		
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$	226,800	226,800		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	9,056	9,056		
b. Other *(Specify)* - Non-Medicare	$	5,432	5,432		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	12,154,323	12,154,323		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	317	317		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	28	28		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$	7,849	7,849		
8. Other (*Specify*)	$	57,056	57,056		
V. Total Other Revenue (1 thru 8)	$	65,250	65,250		
VI. Total All Revenue (III +V)	$	12,219,573	12,219,573		

* *Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.*

** *Facility should report all contractual allowances and/or payer discounts.*

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
		-		
30 II 6a	LAB REV/MED A	$ 6,769		
30 II 6a	X-RAY REV/MED A	$ 2,287		
Total Other Resident Revenue - Medicare		$ 9,056	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
		-		
30 II 6b	LAB REVENUE - PRIVATE PAY	$ 68		
30 II 6b	LAB REVENUE - MEDICAID	$ 57		
30 II 6b	LAB REVENUE - MANAGED CARE	$ 3,250		
30 II 6b	X-RAY MANAGED CARE	$ 2,057		
Total Other Resident Revenue		$ 5,432	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	(Specify)
			-		
30 IV 5	Interest Income	N/A	$ 28		
Total Interest Income			$ 28	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
		-		
30 IV 8	TRANSPORTATION INCOME (Disallowed Expense on Page 16 Line l1)	$ 880		
30 IV 8	ADMINISTRATIVE INCOME (Disallowed on Page 16 Line m13)	$ 24,414		
30 IV 8	UNRESTRICTED DONATION INCOME (Disallowed Expense Page 16 Line m10)	$ 150		
30 IV 8	TRANSPORTATION INCOME (Disallowed Expense on Page 16 Line l1)	$ 21,845		
30 IV 8	SETTLEMENT WITH MEDICAL SOLUTIONS (No Disallowance Necessary)	$ 9,767		
Total Other Revenue		$ 57,056	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Robert C. Geer Memorial Hospital, Inc.	843-C	9/30/2025	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 150,188
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 2,372,950
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 150,686
a. PREPAID INS-COMM/PROP/LIAB		50,117		
b. PREPAID INS-AUTO PACKAGE		2,225		
c. PREPAID INS-D & O LIAB		14,329		
d. See Schedule		84,015		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,673,824
B. Fixed Assets				
1. Land				$ 137,129
2. Land Improvements	*Historical Cost	144,976		$ 1,398
	Accum. Depreciation	143,578	Net	
3. Buildings	*Historical Cost	3,273,861		$ 620,484
	Accum. Depreciation	2,653,377	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	86,403		$ 46,130
	Accum. Depreciation	40,273	Net	
6. Movable Equipment	*Historical Cost	876,798		$ 38,337
	Accum. Depreciation	838,461	Net	
7. Motor Vehicles	*Historical Cost	62,148		$
	Accum. Depreciation	62,148	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 31,527
F/S vs CR NBV		(42,033)		
See Schedule		73,560		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 875,005

* 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	A5	PREPAID OTHER	$ 84,015
Total Prepaid Expenses			$ 84,015

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	
31	B9	CONSTRUCTION IN PROGRESS	$ 73,560
Total Other Other Fixed Assets (Itemize)			$ 73,560

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
Robert C. Geer Memorial Hospital, Inc.	843-C	9/30/2025	32	37

Account				Amount
			Total Brought Forward:	$ 3,548,829
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*)				$ 2,996,639
Name and Address	Amount	Loan Date		
Due From>Various	2,996,639			
7. Other Assets (*itemize*)				$ 50,861
PATIENT TRUST FUNDS		50,861		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 3,047,500
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 6,596,329

* 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
Robert C. Geer Memorial Hospital, Inc. d/b/a	843-C	9/30/2025	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 1,432,375
2. Notes Payable (*itemize*)				$ 40,979
CURRENT PORTION - HUD	40,979			
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*)				$ 311,038
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*)				$ 24,750
11. Accrued Income Taxes*				$
12. Other Current Liabilities (*itemize*)				$ 1,762,176
CT USER TAX PAYABLE	139,826			
PATIENT FUNDS PAYABLE	50,921			
DEFERRED INCOME	1,571,429			
See Schedule				
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 3,571,318

* 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
Robert C. Geer Memorial Hospital, Inc. d/b/a	843-C	9/30/2025	34	37

Account	Amount
Total Brought Forward:	3,571,318
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$ 2,013,091
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)		$ (10,429)
HUD FINANCING COSTS	(12,034)	
AMORIZATION-FINANCE COSTS	1,605	
See Schedule		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 2,002,662
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 5,573,980

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

Name of Facility	License No.	Report for Year Ended	Page	of
Robert C. Geer Memorial Hospital, Inc	843-C	9/30/2025	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. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 744,698
	6. Gain or Loss for Period 10/1/2024 thru 9/30/2025	$ 277,651
	7. Total Net Worth	$ 1,022,349
C.	***Total Reserves and Net Worth***	$ 1,022,349
D.	***Total Liabilities, Reserves, and Net Worth***	$ 6,596,329

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Robert C. Geer Memorial Hospital, Inc.	843-C	9/30/2025	36	37

	Account	Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2024	$ 961,382
B.	Total Revenue (*From Statement of Revenue Page 30*)	$ 12,219,573
C.	Total Expenditures (*From Statement of Expenditures Page 27*)	$ 11,941,922
D.	Net Income or Deficit	$ 277,651
E.	Balance	$ 1,239,033
F.	Additions	
	1. Additional Capital Contributed (*itemize*)	
	Expenses Per Page 27 $11,960,122	
	F/S vs C/R Depreciation ($18,200)	
	Expenses Per FS $11,941,922	
	2. Other (*itemize*)	
	Prior Period Adjustments (216,684)	
F-3.	Total Additions	$ (216,684)
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*** 09/30/25	$ 1,022,349

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Robert C. Geer Memorial Hospital, Inc.	843-C	9/30/2025	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined	☐ (Specify)	☐ (Specify)

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. 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 in the Adjustments columns. 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

Printed Name of Preparer
Matthew S. Bavolack

Addres Address	Phone Number
6 Research Drive Suite 450, Shelton, CT 06484	203-366-5876

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Shaun Powell	860-824-3860

Contact Email Address
spowell@geercares.org