State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2019

Name of Facility (as licensed) Leeway, Inc.		
Address (No. & Street, City, State, Zip Code) 40 Albert St, New Haven, Ct		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☑ Residential Care Home
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019	

License Numbers:	CCNH	RHNS	Residential Care Home	Medicare Provider
	2167-C		1891-RCH	07-5408

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	42169		

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2019	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 Leeway, Inc. [facility name], for the cost report period beginning October 1, 2018 and ending September 30, 2019, 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) Jay Katz			Printed Name (Owner) William Dyson, Chairman	
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

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Name of Facility Leeway, Inc.	Period Covered:		From 10/1/2018	To 9/30/2019
Address of Facility 40 Albert St, New Haven, Ct				
Report Prepared By Robert Morgan, CPA	Phone Number 941 303-3958		Date	

Item		Total	CCNH	RHNS	Residential Care Home
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
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Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Leeway, Inc.	40 Albert St, New Haven, Ct

License Numbers:	CCNH	RHNS	Residential Care Home	Medicare Provider No.
	2167-C		1891-RCH	07-5408

Type of Facility (Check appropriate box(es))

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

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.:	
Jay Katz		

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2019	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
Leeway, Inc	40 Albert St, New Haven, Ct.	Connecticut

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
William Dyson, Chairman			
Patricia Comer, Vice Chairperson			
Russell Barbour, PhD			
Stuart Sidle, PhD			
Katgryn, Sylvester, Esq.			
Names of Stockholders Owning at Least 10% of Shares			
Frederick Streets, PhD			
Jeffrey Busk			
Elaine Anderson			
Robert Morgan, CPA			
Michael Dunn, Esq.			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2019	3B	37

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Robert Morgan		○	⊙		accounting, cost reports and other reimb rela	P.10/A.4	33,780	33,780
Leeway Putman		○	⊙		Rental of grant funded office space			
Leeway Welton		○	⊙		Rental of grant funded office space			
Leeway Scattered Site		○	⊙		None			
Michael Dunn, Esq. / Greentree Risk Management		⊙	○	100%	Labor Relations Risk Management	P10 / L	3,000	3,000
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

* 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.

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

Costs associated with management oversight of housing and grants has been eliminated from the cost report along with direct costs associated with each grant program. The details are included on the general ledger cross reference schedule included with the cost report submission.

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Pitney Bowes	○	⊙	Postage Meter			785	785
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total *** 785

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

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General Information and Questionnaire
Accounting Basis

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

1	Audited Financial Statements, Single Audit, and Form 990	$ 29,820
2	Note: Costs associated with Consolidation are paid proportionately by each entity.	$
3		$
4		$
		Charge for Services Provided $ 29,820

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

⊙ Yes ○ No

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Greentree Labor Risk Management	
2 Various - Non Reimburseable Labor Related	
3	
4	
5	

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	Labor Risk Management	$ 3,000
2	Labor Lawsuites - Self Disallowed Page 28	$ 20,330
3		$
4		$
5		$
		Charge for Services Provided $ 23,330

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

⊙ Yes ○ No

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total Residential Care Home	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Residential Care Home	Total	CCNH	RHNS	Residential Care Home
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	60	30		30	60	30		30	60	30		30
B. On last day of THIS report period	60	30		30	60	30		30	60	30		30
2. Number of Residents												
A. As of midnight of PREVIOUS report period	59	30		29	59	30		29	56	27		29
B. As of midnight of THIS report period	56	27		29	56	27		29	56	27		29
3. Total Number of Days Care Provided During Period												
A. Medicare	637	637			434	434			203	203		
B. Medicaid (Conn.)	10,127	10,127			7,568	7,568			2,559	2,559		
C. Medicaid (other states)												
D. Private Pay	365			365	273			273	92			92
E. State SSI for RCH	10,283			10,283	7,671			7,671	2,612			2,612
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	21,412	10,764		10,648	15,946	8,002		7,944	5,466	2,762		2,704
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)**	21,412	10,764		10,648	15,946	8,002		7,944	5,466	2,762		2,704

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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 (1)	RHNS (2)	Residential Care Home (3)	Lost (1)	Lost (2)	Lost (3)	Gained (1)	Gained (2)	Gained (3)	CCNH	RHNS	Residential Care Home	

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	Residential Care Home
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	Residential Care Home	R.C.H.	ICF-MR
No. of Residents	1	26						
Per Diem Rate								
a. One bed rm.	Var	424.84				170.00		
b. Two bed rms.								
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	Residential Care Home
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	231	231		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	568	568		
C. Other	438	438		
D. ***Total Physical Therapy Treatments***	1,237	1,237		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	59	59		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	233	233		
C. Other	82	82		
D. ***Total Speech Therapy Treatments***	374	374		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	318	318		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	313	313		
C. Other	623	623		
D. ***Total Occupational Therapy Treatments***	1,254	1,254		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2019	10	37

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	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)	85,738	1,371			22,964	367
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	136,448	3,105			31,207	550
5. Dietary Service						
a. Head Dietitian	6,648	155			6,577	153
b. Food Service Supervisor	29,311	992			28,996	982
c. Dietary Workers	158,174	8,948			156,469	8,851
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	66,934	1,144			50,775	868
b. Other Maintenance Workers	17,991	516			13,647	392
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services	127,898	6,781			97,022	5,144
11. Accounting Services						
a. Head Accountant	72,851	1,400			19,512	375
b. Other Accountants	172,464	6,147			46,193	1,646
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	108,670	2,080				
b. RN						
1. Direct Care	417,672	9,928				
2. Administrative**	122,554	2,869				
c. LPN						
1. Direct Care	187,349	5,973				
2. Administrative**						
d. Aides and Attendants	537,847	25,563			307,295	15,555
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	54,332	2,293			18,111	765
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	117,142	3,881			16,560	543
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	2,420,023	83,146			815,328	36,191

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		Residential Care Home	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		Residential Care Home	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Chaplain	$ 3,327	167			$ 3,292	165
Total	$ 3,327	167	$ -	-	$ 3,292	165

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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	Residential Care Home							
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
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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	Residential Care Home							
Section III - Administrators* **										
Jay Katz	85,738		22,964	Standard Employee Package	CEO Oversight of Operations & Housing	1,738	A.2	Housing & Grants	342	17,667
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
Leeway, Inc.	2167-C	9/30/2019	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist	2,403	48				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	102,661	1,258				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	36,000	196				
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)	13,832	96				
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	16,676	572				
b. Other						
10. Occupational Therapist						
a. Resident Care	51,420	660				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	48,054	688				
2. Administrative***						
b. LPN						
1. Direct Care	4,042	72				
2. Administrative***						
c. Aides	3,852	8				
d. Other						
12. Other (Specify)						
See Attached Schedule	3,327	167			3,292	165
B-13 Total Fees Paid in Lieu of Salaries	282,267	3,765			3,292	165

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2019	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Procare LTC of Ct	Pharmacy Consultant	○	⊙	
Foremost Rehab	PT< OT, & ST	○	⊙	
Anuradda Walaliyadda, MD	Medical Director	○	⊙	
Yale School Of Medicine	MD Adnin - Staff Dev.	○	⊙	
The Nurse Network	Nurse Staffing	○	⊙	
AAA Nursing Care	Nurse Staffing	○	⊙	
Maxim Staffing	Nurse Staffing	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
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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
Leeway, Inc.	2167-C	9/30/2019	15	37

Item		Total	CCNH	RHNS	Residential Care Home
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	63,144	47,231		15,913
2. Disability Insurance	$				
3. Unemployment Insurance	$	34,027	25,452		8,575
4. Social Security (F.I.C.A.)	$	243,159	181,881		61,278
5. Health Insurance	$	265,726	198,761		66,965
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	78,415	58,654		19,761
(not-owners and not-operators)					
8. Uniform Allowance	$	996	501		495
9. Other (*Specify*)	$	(11,574)	(8,657)		(2,917)
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans forOwners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	56,587	28,447		28,140
d. Accounting and Auditing	$	29,820	23,520		6,300
e. Legal (*Services should be fully described on Page 7)*	$	23,330	18,401		4,929
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	13,213	10,422		2,791
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	28,339	22,352		5,987
2. Cellular Phones	$	3,405	2,686		719
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	$	213,037	213,037		
Subtotal	$	1,041,624	822,688		218,936

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Residential Care Home
Employee Assistance Program	$ 367		$ 123
Benefit Allocations to Grants & Housing	$ (9,024)		$ (3,040)
Total	$ (8,657)	$ -	$ (2,917)

Schedule of Other Taxes

Description	CCNH	RHNS	Residential Care Home
Total	$ -	$ -	$ -

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2019	16	37

Item		Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:		1,041,624	822,688		218,936
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	4,889	3,856		1,033
3. Gifts to Staff and Residents	$	5,125	4,042		1,083
4. Employee Travel	$	740	584		156
5. Education Expenses Related to Seminars and Conventions	$	25,237	19,905		5,332
6. Automobile Expense (*not purchase or depreciation*)	$	3,772	2,975		797
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	7,231	5,703		1,528
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$				
See Attached Schedule					
4. Fund-Raising***	$	9,706	7,656		2,050
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	2,125	1,676		449
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	8,104	6,391		1,713
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	618	487		131
9. Subscriptions	$	266	210		56
10. Contributions***	$				
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	125,749	106,939		18,810
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	96,121	70,518		25,603
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	1,331,307	1,053,630		277,677

* 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	Residential Care Home
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	Residential Care Home
Total Other Advertising	$ -	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
Leading Age	$ 4,818		$ 1,291
ALTCFM	$ 225		$ 60
CARCH	$ 394		$ 106
ACHCA	$ 162		$ 43
ACT Aids CT	$ 118		$ 32
CAHCF	$ 276		$ 74
CT Coalition Homeless	$ 256		$ 69
CBIA	$ 237		$ 63
BJ	$ (95)		$ (25)
Total Dues	$ 6,391	$ -	$ 1,713

Schedule of Contributions

Description	CCNH	RHNS	Residential Care Home
Total Contributions	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
Website	$ 1,577		$ 423
Employee Service Awards	$ 1,261		$ 338
Licenses & Fees	$ 2,241		$ 600
Bank Charges	$ 5,541		$ 1,484
New Employee Hire	$ 6,656		$ 1,783
Health & Drug Screening	$ 6,259		$ 1,677
Employee Background Checks	$ 5,816		$ 1,558
Nursing Home Week Celebration	$ 1,001		$ 268
Volunteer Appreciation	$ 418		$ 112
Computer Supplies & Minor Equ	$ 2,395		$ 642
Cable TV - Allowable	$ 1,800		$ 1,800
Board of Directors Expense	$ 73		$ 19
Self Disallowances:			
Cable TV	$ 7,368		$ 7,369
Penalties And Late Fees	$ 1,235		$ 331
Lobbying Expenses	$ 10,254		$ 2,746
Barber & Beauty	$ 315		$ 85
Resident Personal Items	$ 1,728		$ 463
Non-Reimburseable	$ 14,580		$ 3,905
Total Other Administrative and General	$ 70,518	$ -	$ 25,603

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CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2019	Page 17 | of 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #

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

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CSP-18 Rev. 9/2018

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
Leeway, Inc.	2167-C	9/30/2019	18 | 37

Item		Total	CCNH	RHNS	Residential Care Home
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	182,797	91,894		90,903
2. Non-Food Supplies	$	19,903	10,005		9,898
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	9,569	4,810		4,759
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	212,269	106,709		105,560

2E. Dietary Questionnaire	Total	CCNH	RHNS	Residential Care Home
F. Resident Meals: Total no. of meals served per day:*	174	89		86

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

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

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CSP-19 Rev. 9/2018

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

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2019		Page of 19 | 37

Item		Total	CCNH	RHNS	Residential Care Home
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)*	$	29,004	26,484		2,520
c. Other (*Specify*)	$				
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	29,004	26,484		2,520

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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CSP-20 Rev. 9/2018

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
Leeway, Inc.	2167-C	9/30/2019	20	37

Item			Total	CCNH	RHNS	Residential Care Home
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	25,510	21,517		3,993
b. Purchased Services (*by contract other than through Management Services*)	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$	208,504	155,920		52,584
C. Other (*Specify*)		$	7,058	4,013		3,045
Minor Equip & Furniture						
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	241,072	181,450		59,622
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	81,957	81,957		
Procare of Connecticut						
b. Medicine Cabinet Drugs		$	12,807	12,807		
c. Medical and Therapeutic Supplies		$	87,207	87,207		
d. Ambulance/Limousine***		$	73	73		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	8,247	8,247		
f. X-rays and Related Radiological Procedures***		$	35	35		
g. Dental (*Not dentists who should be included under salaries or fees)*		$	3,420	3,420		
h. Laboratory***		$	9,275	9,275		
i. Recreation		$	4,800	3,600		1,200
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)****		$	9,203	7,207		1,996
See Attached Schedule						
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	217,024	213,828		3,196

* 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	Residential Care Home
Medical Equip - Title 19	$ 2,341		$ -
Wound Vac - Medicaid	$ 458		$ -
IV - T-19	$ 2,121		$ -
Minor Equip & Furniture - Nursing	$ 2,287		$ -
RCH SUPPLIES	$ -		$ 1,996
Total Other Resident Care	$ 7,207	$ -	$ 1,996

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CSP-21 Rev. 10/2001

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

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2019	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	Residential Care Home	Pg	Line
Checkwriters		○	⊙		Payroll Processing	11,568		3,098	16	C.1.m
EBM IT Services		○	⊙		Computer Server Services	32,703		8,759	16	C.1.m
Point Click Care		○	⊙		Software User Fee & Maintenance	18,209		4,877	16	C.1.m
Creatice Financial Staffing		○	⊙		Temporary Booking Staff	36,408			16	C.1.m
Diversified Services		○	⊙		Housekeeping	155,920		52,584	20	C.4.b
Unitex		○	⊙		Laundry	26,484		2,520	19	C.3.b
Controlled Air		○	⊙		HVAC	6,450		4,893	22	C.6.f
All Around		○	⊙		Snow Removal	13,647		10,353	22	C.6.f
Connecticut Business Machines		○	⊙		Office Equipment Maintenance	8,625		6,542	22	C.6.f
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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
Leeway, Inc.	2167-C	9/30/2019	22 | 37

Item		Total	CCNH	RHNS	Residential Care Home
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	19,554	11,119		8,435
b. Heat	$	32,029	18,213		13,816
c. Light & Power	$	112,605	64,031		48,574
d. Water	$	18,773	10,675		8,098
e. Equipment Lease (*Provide detail on page 6*)	$	785	446		339
f. Other (*itemize*)	$	148,242	87,146		61,096
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	331,988	191,630		140,358
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	20,394	11,597		8,797
b. Building & Building Improvements	$	292,995	166,608		126,387
c. Non-Movable Equipment	$	19,733	11,221		8,512
d. Movable Equipment	$	69,931	39,766		30,165
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	403,053	229,192		173,861
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	7,947	4,519		3,428
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	7,947	4,519		3,428
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)	$	411,000	233,711		177,289

* 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	Residential Care Home
Purchased Service - Plumber	$ 3,715		$ 2,818
Purch Service - HVAC	$ 6,450		$ 4,893
Purchased Services - Electric	$ 6,614		$ 5,018
Purch Serv - Exterminator	$ 2,246		$ 1,704
Purchased Serv - Alarm Service	$ 801		$ 607
Purch Service - Fire Protecti	$ 3,171		$ 2,405
Purch Serv - Sec camera Main	$ 3,293		$ 2,498
Purch Service - Ridgefield As	$ 4,777		$ 3,623
Purch Service - Elevator	$ 3,669		$ 2,783
Purchased Service - Locksmith	$ 586		$ 444
Purch Service - Telephone Rep	$ 3,092		$ 2,346
Purch Serv - Nurse Call System	$ 159		$ 120
Purchased Service - Shredding	$ 4,200		$ -
Purchased Service - Generator	$ 3,246		$ 2,463
Purch Serv - Snow Removal	$ 13,647		$ 10,353
Purch Service - Med Equip Ins	$ 1,793		$ 1,361
Purch Services - Legionella Rist Ass	$ 2,559		$ 1,941
Trash Removal- Maint	$ 5,245		$ 3,978
Medical Waste Removal	$ 2,405		$ -
Landscaping	$ 6,853		$ 5,199
Office Equip Maint Agreements	$ 8,625		$ 6,542
Total Other Repairs and Maintenance	$ 87,146	$ -	$ 61,096

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2019	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	305,769		305,769	68,152	S/L	Var	20,394	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								20,394
B. **Building and Building Improvements**								
1. Acquired prior to this report period	8,062,301		8,062,301	3,500,553	S/L	Var	292,902	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	3,700		3,700		S/L	Var	93	
B-4. Subtotal								292,995
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	328,630		328,630	139,695	S/L	Var	19,518	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	6,452		6,452		S/L	Var	215	
C-4. Subtotal								19,733

	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. 2005 Mazda	x		4	2007	14,983		14,983	14,983	S/L	5		
b. 2017 Ford Bus	x		8	2017	68,717		68,717	23,859	S/L	6	11,453	
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					653,449		653,449	329,562	S/L	Var	58,179	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					5,986		5,986		S/L	Var	299	
D-3. Subtotal												69,931
E. ***Total Depreciation***												403,053

Schedule of Land Improvements Acquired during this report peri

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

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

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

Schedule of Building Improvements Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
5/15/2019	First Response Sewer & Drain - Sewer Pump	$ 3,700	20	$ 93	
5/20/2019					
Total additions for Building Improvemen		$ 3,700		$ 93	*
Deletions:					
Total deletions for Building Improvement		$ -		$ -	**

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

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

Schedule of Non-Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
1/4/2019	Coastline Mechanical Services - Sewer Ejector Pump	$ 2,002	15	$ 67	
5/20/2019	Coastline Mechanical Services - Hot Water Heater	$ 4,450	15	$ 148	
Total additions for Non-Movable Equipmen		$ 6,452		$ 215	*
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 peri

Acquisition Dat	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/16/2018	McKesson - PT Lift with scale	$ 5,986	10	$ 299	
Total additions for Movable Equipmen		$ 5,986		$ 299	*
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 peri

Acquisition Dat	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
Leeway, Inc.	2167-C	9/30/2019	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. Financing Costs Key Bank - Mortgag	12	2014	15	20,361	7,635	S/L		2,036	
2. Financing Costs Key Bank - Mortgag	12	2014	20	59,107	16,255	S/L		5,911	
3.									
B-4. Subtotal									7,947
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***									7,947

* 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
Leeway, Inc.	2167-C	9/30/2019	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	01/01/96
2. Date Structure Completed	10/01/96
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	60
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)	Variable	Fixed		
b. Date Mortgage Obtained	12/29/14	12/29/14		
c. Interest Rate for the Cost Year	4.0-5.0%	50.00%		
d. Term of Mortgage (number of years)	15	20		
e. Amount of Principal Borrowed	800,000	3,355,000		
f. Principal balance outstanding as of _____	477,205	2,809,813		
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Leeway, Inc.	2167-C	9/30/2019	26 | 37

Item		Total	CCNH	RHNS	Residential Care Home
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$	27212	15,474		11,738
Name of Lender: Key Bank	Rate: Variable				
Address of Lender					
2. Second Mortgage	$	159,443	90,665		68,778
Name of Lender: Key Bank	Rate: 5.00%				
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)	$	186,655	106,139		80,516

(*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
Leeway, Inc.	2167-C	9/30/2019	27 | 37

Item			Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:			186,655	106,139		80,516
12. C. Movable Equipment						
1. Automotive Equipment		$	1,627	925		702
A. Item	Rate	Amount				
Van/Bus - 2017						
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)		$	1,627	925		702
12. D. Other Interest Expense (*Specify*)		$	856	487		369
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)		$	189,138	107,551		81,587
14. Insurance						
a. Insurance on Property (buildings only)		$	17,164	8,628		8,536
b. Insurance on Automobiles		$	8,274	4,159		4,115
c. Insurance other than Property (as specified above)						
1. Umbrella (*Blanket Coverage*)		$	25,179	18,834		6,345
2. Fire and Extended Coverage		$				
3. Other (*Specify*)		$	17,382	13,002		4,380
Fid. Bond, Cyber, D&O, Crime						
14d. ***Total Insurance Expenditures (14a + b + c)***		$	67,999	44,623		23,376
15. ***Total All Expenditures (A-13 thru C-14)***		$	6,551,711	4,861,906		1,689,805

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Leeway, Inc.	2167-C	9/30/2019	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.	13	B.10.a	Occupational Therapy $	51,420	51,420		
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1.c	Bad Debts $	56,587	28,447		28,140
10.			Accounting $				
10a.			Legal $	20,330	16,035		4,295
11.	15	1.h	Telephone $	1,760			1,760
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.			Unallowable Advertising * $				
19.			Income Tax / Corporate Business Tax $				
20.	16	m.4	Fund Raising / Contributions $	10,106	7,857		2,249
21.	16	m.6	Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	49,648	40,597		9,051
Page 18 - Dietary Expenditures							
24.	30		Meals to employees, guests and others who are not residents $	60	30		30
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	189,911	144,386		45,525

* 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	Residential Care Home
Total Other Salaries Adjustment			$ -	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Fees Adjustments			$ -	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
16	c.14	Cable TV	$ 6,809		$ -
16	c.14	Penalties And Late Fees	$ 1,235		$ 331
16	c.14	Lobbying Expenses	$ 10,254		$ 2,746
16	c.14	Resident Personal Items	$ 1,728		$ 463
16	c.14	Non-Reimburseable	$ 14,580		$ 3,905
27 / 16		2002 Ford Insurance, gas & repar	$ 1,615		$ 433
27 / 16		2007 Mazda Insurance, gas & repair	$ 3,889		$ 1,042
16	8.a	Chamber of Comerce Dues	$ 487		$ 131
Total Other A&G Adjustments			$ 40,597	$ -	$ 9,051

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

Name of Facility	License No.	Report for Year Ended	Page of
Leeway, Inc.	2167-C	9/30/2019	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	Residential Care Home
			Subtotals Brought Forward	$	189,911	144,386		45,525
Page 20 - Resident Care Supplies***								
27.			Prescription Drugs	$	81,957	81,957		
28.			Ambulance/Limousine	$	73	73		
29.			X-rays, etc	$	35	35		
30.			Laboratory	$	8,349	8,349		
31.			Medical Supplies	$				
32.			Oxygen (non emergency)	$				
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$				
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$				
36.			Depreciation on Unallowable Motor Vehicles	$				
37.			Unallowable Property and Real Estate Taxes	$				
38.			Rental of Building Space or Rooms	$				
39.			Other - See Attached Schedule	$				
Page 27 - Insurance								
40.			Mortgage Insurance	$				
41.			Property Insurance	$				
Other - Miscellaneous								
42.			Other - Indirect	$				
43.			Interest Income on Account Rec.	$				
44.			Other - Miscellaneous Administrative	$	8,386	230		8,156
45.			Management Fees Direct	$				
46.			Management Fees Indirect	$				
47.			Other - Direct	$				
Not For Profit Providers Only								
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	$				
49.	***Total Amount of Decrease (Items 1 - 48)***			$	288,711	235,030		53,681

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

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Ancillary Costs			$ -	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Property Adjustments			$ -	$ -	$ -

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home

Total Other Adjustments			$ -	$ -	$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
30		Cable T.V Revenue - RCH			$ 7,928
30		Misc Revenue	$ 230		$ 228
Total Other Adjustments			$ 230	$ -	$ 8,156

Schedule of Other - Direct Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Adjustments			$ -	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Leeway, Inc.	2167-C	9/30/2019	30 | 37

Item		Total	CCNH	RHNS	Residential Care Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	6,198,945	4,519,505		1,679,440
b. Medicaid Room and Board Contractual Allowance **	$	(412,877)	(294,708)		(118,169)
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	285,300	285,300		
b. Medicare Room and Board Contractual Allowance **	$	439,808	439,808		
4. a. Private-Pay Residents and Other	$	62,050			62,050
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	82,899	82,899		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(82,899)	(82,899)		
c. Prescription Drugs - Non-Medicare	$				
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	$	71,884	71,884		
b. Physical Therapy - Medicare Contractual Allowance **	$	(59,592)	(59,592)		
c. Physical Therapy - Non-Medicare	$	56,897	56,897		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(56,797)	(56,797)		
4. a. Speech Therapy - Medicare	$	14,843	14,843		
b. Speech Therapy - Medicare Contractual Allowance **	$	(10,936)	(10,936)		
c. Speech Therapy - Non-Medicare	$	23,256	23,256		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(23,256)	(23,256)		
5. a. Occupational Therapy - Medicare	$	98,656	98,656		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(72,679)	(72,679)		
c. Occupational Therapy - Non-Medicare	$	31,445	31,445		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(31,445)	(31,445)		
6. a. Other *(Specify)* - Medicare	$	8,598	8,598		
b. Other *(Specify)* - Non-Medicare	$	(4,799)	(4,799)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	6,619,301	4,995,980		1,623,321
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	60	30		30
2. Rental of rooms to non-residents	$				
3. Telephone	$	1,760			1,760
4. Rental of Television and Cable Services	$	7,928			7,928
5. Interest Income *(Specify)*	$	1,986	998		988
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	38,769	28,646		10,123
V. Total Other Revenue (1 thru 8)	$	50,503	29,674		20,829
VI. Total All Revenue (III +V)	$	6,669,804	5,025,654		1,644,150

* *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	Residential Care Home
	Radiology-Medicare	$ 675		
	Lab- Medicare	$ 7,602		
	Lab Revenue Medicare Replacement	$ 321		
Total Other Resident Revenue - Medicare		$ 8,598	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
	Medicare Part A Allowance Reclass	$ (8,598)		
	Anc Allow Medicare Replacement	$ 3,799		
Total Other Resident Revenue		$ (4,799)	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	Residential Care Home
	Money Market & Board Designated Fund		$ 998		$ 988
Total Interest Income			$ 998	$ -	$ 988

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
	Misc. Revenue	$ 230		$ 228
	Reclass of YE Audit Adjustments	$ (1,306)		$ (1,291)
	CLM Donations	$ (160)		$ (159)
	Fund Raiser-Annual Appeal	$ 1,269		$ 1,256
	Donations - Unrestricted	$ 27,772		$ 9,257
	Donations - United Way	$ 841		$ 832
Total Other Revenue		$ 28,646	$ -	$ 10,123

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2019	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 568,567
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 611,570
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 20,179
4 Inventories				$
5. Prepaid Expenses				$ 24,630
a.				
b.				
c.				
d. See Schedule		24,630		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,224,946
B. Fixed Assets				
1. Land				$ 581,784
2. Land Improvements	*Historical Cost	305,769		$ 217,223
	Accum. Depreciation	88,546	Net	
3. Buildings	*Historical Cost	8,066,001		$ 4,272,453
	Accum. Depreciation	3,793,548	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	335,082		$ 175,654
	Accum. Depreciation	159,428	Net	
6. Movable Equipment	*Historical Cost	659,435		$ 271,395
	Accum. Depreciation	388,040	Net	
7. Motor Vehicles	*Historical Cost	83,700		$ 33,405
	Accum. Depreciation	50,295	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 2,424,361
See Schedule		2,424,361		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 7,976,275

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
		Prepaid Insurance	$ 17,670
		Prepaid Dues	$ 1,588
		Prepaid Relias	$ 2,877
		Prepaid Time & Attendance	$ 1,042
		Prepaid IT	$ 158
		Prepaid Fire Alarm Maint	$ 1,295
Total Prepaid Expenses			$ 24,630

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	
		Assets (Net of Accum Depr) - Non-Reimbursable	$ 2,422,901
		CIP - Elevator	$ 1,460
Total Other Other Fixed Assets (Itemize)			$ 2,424,361

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Board Designated Fund	$ 301,403
		Deferred Financinf Key Mortg #1	$ 20,361
		Deferred Financinf Key Mortg #2	$ 59,107
		Accum Amortz - Key #1	$ (9,671)
		Accum Amortz - Key #2	$ (22,165)
Total Other Assets			$ 349,035

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
		Note Payable - UI	$ 26,693
Total Notes Payable			$ 26,693

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

Page Ref	Line Ref	Description	
		Resident Trust	$ 11,072
		Accrued Provider Tax	$ 53,853
		Deferred Income- Grants	$ 264,727
Total Other Current Liabilities (Itemize)			$ 329,652

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

Page Ref	Line Ref	Description	
		DSS Bond Advance	$ 1,875,000
		Mortgage Swap Liability	$ (62,741)
Total Other Current Liabilities (Itemize)			$ 1,812,259

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2019	32	37

Account				Amount
			Total Brought Forward:	$ 9,201,221
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 349,035
See Schedule		349,035		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 349,035
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 9,550,256

* 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
Leeway, Inc.	2167-C	9/30/2019	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 350,032
	2. Notes Payable (*itemize*)				$ 26,693
	See Schedule		26,693		
	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*)				$ 142,384
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 9,602
	7. Medicare Final Settlement Payable				$
	8. Medicare Current Financing Payable				$
	9. Mortgage Payable (*Current Portion*)				$
	10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
	11. Accrued Income Taxes*				$
	12. Other Current Liabilities (*itemize*)				$ 329,652
	See Schedule		329,652		
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 858,363

* 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
Leeway, Inc.	2167-C	9/30/2019	34	37

Account	Amount
Total Brought Forward:	858,363
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$ 21,569

Name of Lender	Purpose	Amount	Date Due
TCF	Van	21,569	8/1/23

2. Mortgages Payable	$ 3,287,018
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date
Key Bank		

4. Other Long-Term Liabilities (*itemize*)	$ 1,812,259
See Schedule 1,812,259	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 5,120,846
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 5,979,209

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

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2019	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	$ 3,355,266
	6. Gain or Loss for Period 10/1/2018 thru 9/30/2019	$ 215,781
	7. Total Net Worth	$ 3,571,047
C.	***Total Reserves and Net Worth***	$ 3,571,047
D.	***Total Liabilities, Reserves, and Net Worth***	$ 9,550,256

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2019	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2018			$ 3,355,266
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 6,669,904
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 6,551,711
D.	Net Income or Deficit			$ 118,193
E.	Balance			$ 3,473,459
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Grant Housing & Non-Reimb Revenue		868,179	
	Grant Housing & Non-Reimb Expenses		(770,591)	
	2. Other (*itemize*)			
F-3.	Total Additions			$ 97,588
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***	09/30/19		$ 3,571,047

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-37 Rev. 9/2002

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2019	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
Robert Morgan, CPA

Addres Address	Phone Number
13872 Posada St, Venice, Fl 34293	941 303-3958

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Roland Beneke	203 865-0068

Contact Email Address
rbeneke@leeway.net