State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2018

Name of Facility (as licensed) Leeway, Inc.		
Address (No. & Street, City, State, Zip Code) 40 Albert Street, 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 10/1/2017	Report for Year Ending 9/30/2018	

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2018	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, 2017 and ending September 30, 2018, 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)

Table of Contents

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1A Rev. 6/95

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Leeway, Inc.	Period Covered:		From 10/1/2017	To 9/30/2018
Address of Facility 40 Albert Street, New Haven, CT				
Report Prepared By Robert Morgan, CPA	Phone Number 941 303-3958		Date 2/6/2019	

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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-2 Rev. 10/2005

General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203 865-0068	9/30/2018	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Leeway, Inc.	40 Albert Street, 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.:
Heather Aaron	001635

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

Name	License No.:

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3 Rev. 10/2005

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2018	3	37

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

Name of Partners/Members	Business Address	Title	% Owned

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3A Rev. 10/2005

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2018	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 Chair	
Russell Barbour		Director	
Kristin Bures		Director	
Kathryn Sylvester, Esq.		Director	
Names of Stockholders Owning at Least 10% of Shares			
Bruce Douglas MD.			Director
Shenae Draughn			Director
Martha Okafor			Director
Melinda Schoen			Director
Stuart Sidle			Director

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3B Rev. 10/2005

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2018	3B	37

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

Owner(s) of Facility

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-4 Rev. 10/2005

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2018	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	%**				
Leeway Putnam Housing Corp		○	⊙		Rental of Case Management offices & alloca			
Leeway Welton Housing Corp		○	⊙		Rental of Case Management offices & alloca			
Leeway Scattered Site Housing Corp		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-5 Rev. 9/2002

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2018	5	37

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.

All costs associated with grants and housing are allocated to programs that are eliminated from the annual cost report. OPM and DSS regulations followed.

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.

All costs associated with grants and housing are allocated to programs that are eliminated from the annual cost report. OPM and DSS regulations followed.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-6 Rev. 9/2002

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
Leeway, Inc.	2167-C	9/30/2018	6	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
Pitney Bowes	○	⊙	Postage Meter		60 Months	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-7 Rev. 6/95

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2018	7	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 Cohn Resnick	
2 Blum Shapiro	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Audit	$ 22,007
2	Form 990	$ 2,000
3		$
4		$
		Charge for Services Provided $ 24,007

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

⊙ Yes ○ No Page 15 Accounting

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Katherine B. Sacks, Esq	
2 Greentree Risk Management	
3 Chubb Insurance	
4	
5	

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	Corporate & Regulatory Advisory	$ 16,197
2	Labor Relations Advisory	$ 3,000
3	Retention - Employee Lawsuit - DSALLOWED	$ 10
4		$
5		$
		Charge for Services Provided $ 19,207

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

○ Yes ⊙ No Page 15, legal

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 9/2002

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2018	8	37

	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	58	29		29	58	29		29	59	30		29
B. As of midnight of THIS report period	59	30		29	59	30		29	59	30		29
3. Total Number of Days Care Provided During Period												
A. Medicare	759	759			644	644			115	115		
B. Medicaid (Conn.)	9,932	9,932			7,367	7,367			2,565	2,565		
C. Medicaid (other states)												
D. Private Pay	365			365	273			273	92			92
E. State SSI for RCH	10,349			10,349	7,760			7,760	2,589			2,589
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	21,405	10,691		10,714	16,044	8,011		8,033	5,361	2,680		2,681
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	203	203			131	131			72	72		
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	21,608	10,894		10,714	16,175	8,142		8,033	5,433	2,752		2,681

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

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2018	9	37

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

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH (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	2	28				1	28	
Per Diem Rate								
a. One bed rm.	Var	450.00				160.00	150.00	
b. Two bed rms.								
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	Residential Care Home
A. Medicare - Part B	258	258		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	542	542		
2. Restorative Treatments				
C. Other	630	630		
D. ***Total Physical Therapy Treatments***	1,430	1,430		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	272	272		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	322	322		
2. Restorative Treatments				
C. Other	210	210		
D. ***Total Speech Therapy Treatments***	804	804		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	186	186		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	224	224		
2. Restorative Treatments				
C. Other	500	500		
D. ***Total Occupational Therapy Treatments***	910	910		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2018	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)	129,906	1,136			30,514	267
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	93,306	2,622			15,311	626
5. Dietary Service						
a. Head Dietitian	15,162	441			14,913	434
b. Food Service Supervisor	29,913	953			29,422	937
c. Dietary Workers	146,906	13,047			144,491	12,832
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	56,439	1,240			42,814	940
b. Other Maintenance Workers	30,430	955			23,084	725
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services	121,642	11,514			92,276	8,734
11. Accounting Services						
a. Head Accountant	73,792	1,483			17,333	348
b. Other Accountants	141,427	5,584			33,220	1,312
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	116,939	2,010				
b. RN						
1. Direct Care	488,149	29,152				
2. Administrative**	114,143	2,693				
c. LPN						
1. Direct Care	130,113	5,886				
2. Administrative**						
d. Aides and Attendants	524,852	43,928			290,888	26,732
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	38,879	1,588			12,960	530
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	155,221	5,558			21,372	1,031
n. Marketing						
o. Other (Specify)						
See Attached Schedule	469	24			461	23
A-13. Total Salary Expenditures	2,407,688	129,814			769,059	55,471

* 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**
Chaplain	$ 469	24			$ 461	23
Total	$ 469	24	$ -	-	$ 461	23

Schedule of Other Fees (Page 13)

	CCNH		RHNS		Residential Care Home	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Chaplain	$ 3,343	167			$ 3,288	165
Total	$ 3,343	167	$ -	-	$ 3,288	165

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-11 Rev. 10/2005

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
Leeway, Inc.	2167-C	9/30/2018	11	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-12 Rev. 10/2005

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
Leeway, Inc.	2167-C	9/30/2018	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	Residential Care Home							
Section III - Administrators* **										
Heather Aaron	129,906		30,514	Standard Employee Package	Responsible for day to day operations	1,403		Housing & Grants	677	62,916
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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2018	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	126	3			124	2
2. Dentist						
3. Pharmacist	2,104	48				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	81,799	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	39,994	572				
b. Other						
10. Occupational Therapist						
a. Resident Care	42,455	660				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	46,188	620				
2. Administrative***						
b. LPN						
1. Direct Care	7,425	124				
2. Administrative***						
c. Aides	408	8				
d. Other						
12. Other (Specify)						
See Attached Schedule	3,343	167			3,288	165
B-13 Total Fees Paid in Lieu of Salaries	273,674	3,752			3,412	167

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-14 Rev. 6/95

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	9/30/2018	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Foremost Rehab	PT, OT, & ST	○	⊙	
Procare LTC of CT	Pharmacy Consutant	○	⊙	
Anuruddha Walaliyadda, MD	Medical Director	○	⊙	
Yale School of Medicine	MD Adnin - Staff Dev.	○	⊙	
The Nurse Network	Agency nurse staffing	○	⊙	
AAA Nursing Care	Agency nurse staffing	○	⊙	
Maxim Staffing Solutions	Agency nurse staffing	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
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* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2018	15	37

Item		Total	CCNH	RHNS	Residential Care Home
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	57,851	43,846		14,005
2. Disability Insurance	$				
3. Unemployment Insurance	$	42,847	32,474		10,373
4. Social Security (F.I.C.A.)	$	238,242	180,566		57,676
5. Health Insurance	$	327,911	248,527		79,384
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	179,521	136,061		43,460
(not-owners and not-operators)					
8. Uniform Allowance	$	7,281	3,671		3,610
9. Other (*Specify*)	$	(24,455)	(18,535)		(5,920)
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans forOwners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	44,056	22,210		21,846
d. Accounting and Auditing	$	24,007	19,441		4,566
e. Legal (*Services should be fully described on Page 7)*	$	19,207	15,554		3,653
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	20,824	16,863		3,961
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	29,567	23,942		5,625
2. Cellular Phones	$	1,931	1,564		367
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	$	212,996	212,996		
Subtotal	$	1,181,786	939,180		242,606

* 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
Allocated benefits to grants & housing	$ (18,907)		$ (6,038)
Employee Assistance Fee	$ 372		$ 118
Total	$ (18,535)	$ -	$ (5,920)

Schedule of Other Taxes

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

State of Connecticut
Annual Report of Long-Term Care Facility
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	9/30/2018	16	37

Item		Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:		1,181,786	939,180		242,606
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	12,259	9,927		2,332
3. Gifts to Staff and Residents	$	6,360	5,150		1,210
4. Employee Travel	$	700	567		133
5. Education Expenses Related to Seminars and Conventions	$	67,634	54,769		12,865
6. Automobile Expense (*not purchase or depreciation*)	$	8,514	6,895		1,619
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	4,024	3,259		765
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	673	545		128
See Attached Schedule					
4. Fund-Raising***	$	20,342	16,473		3,869
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	1,357	1,099		258
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	7,621	6,170		1,451
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	602	487		115
9. Subscriptions	$	418	338		80
10. Contributions***	$	300	151		149
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	105,310	91,513		13,797
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	101,090	76,398		24,692
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	1,518,990	1,212,921		306,069

* 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
Advertising	$ 545		$ 128
Total Other Advertising	$ 545	$ -	$ 128

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
Leading Age	$ 3,612		$ 849
ALTCFM	$ 206		$ 49
CARCH	$ 202		$ 48
ACT Aids CT	$ 405		$ 95
CAHCF	$ 567		$ 133
CT Coalition Homeless	$ 182		$ 43
CBIA	$ 972		$ 228
BJ	$ 24		$ 6
Total Dues	$ 6,170	$ -	$ 1,451

Schedule of Contributions

Description	CCNH	RHNS	Residential Care Home
Contributions	$ 151		$ 149
Total Contributions	$ 151	$ -	$ 149

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
Employee Service Awards	$ 266		$ 63
Licenses & Fees	$ 1,569		$ 369
Bank Charges	$ 5,216		$ 1,225
New Employee Hire	$ 20,245		$ 4,755
Health & Drug Screening	$ 7,896		$ 1,855
Employee Background Checks	$ 4,815		$ 1,131
Nursing Home Week Celebration	$ 5,328		$ 1,251
Management & Board Retreat	$ 6,623		$ 1,556
Computer Supplies & Minor Equ	$ 2,791		$ 655
Cable TV - Allowable	$ 1,800		$ 1,800
Board of Directors Expense	$ 210		$ 49
Self Disallowances:			
Cable TV	$ 7,016		$ 7,016
Penalties And Late Fees	$ 113		$ 27
Lobbying Expenses	$ 9,717		$ 2,283
Barber & Beauty	$ 368		$ 87
Alumni Expenses	$ 126		$ 30
Resident Personal Items	$ (103)		$ (24)
	$ 2,402		$ 564
Total Other Administrative and General	$ 76,398	$ -	$ 24,692

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2018	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.**

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-18 Rev. 9/2002

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	9/30/2018	18 | 37

Item		Total	CCNH	RHNS	Residential Care Home
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	181,744	91,625		90,119
2. Non-Food Supplies	$	18,762	9,459		9,303
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	10,044	5,064		4,980
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	210,550	106,148		104,402

2F. Dietary Questionnaire	Total	CCNH	RHNS	Residential Care Home
G. Resident Meals: Total no. of meals served per day:*	176	89		87

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-19 Rev. 9/2002

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 9/30/2018		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)* — $	30,673	28,338		2,335
c. Other (*Specify*) — $				
3D. ***Total Laundry Expenditures*** (3a + b + c) — $	30,673	28,338		2,335

3F.	Laundry Questionnaire			
G.	Is cost of employee laundry included in 3E?	○ Yes	⊙ No	If yes, specify cost.
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 laundry provided to persons other than employees or residents included in 3E?	○ Yes	⊙ No	If yes, specify cost.
K.	Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
L.	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 3E.

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-20 Rev. 9/2002

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	9/30/2018	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.	$	25,672	21,780		3,892
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$	203,697	148,011		55,686
C. Other (*Specify*)		$	6,501	3,697		2,804
Minor furnishings / decorations						
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	235,870	173,488		62,382
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	125,502	125,502		
Procare LTC						
b. Medicine Cabinet Drugs		$	8,558	8,558		
c. Medical and Therapeutic Supplies		$	88,469	88,469		
d. Ambulance/Limousine***		$	501	501		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	7,571	7,571		
f. X-rays and Related Radiological Procedures***		$	607	607		
g. Dental (*Not dentists who should be included under salaries or fees)*		$	1,140	1,140		
h. Laboratory***		$	12,949	12,949		
i. Recreation		$	10,149	7,612		2,537
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)****		$	4,949	3,905		1,044
See Attached Schedule						
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	260,395	256,814		3,581

* 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
Wound Vac Medicare A	$ 2,291		
IV Medicaid	$ 59		
Nursing - Minor Equip	$ 1,555		
RCH supplies			$ 1,044
Total Other Resident Care	$ 3,905	$ -	$ 1,044

State of Connecticut
Annual Report of Long-Term Care Facility
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	9/30/2018	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
Diverssified Buildin Services		○	⊙		Housekeeping	148,011		55,686	20	C.4.b
Unitex		○	⊙		Laundry	28,338		2,335	19	C.3.b
Checkwriters		○	⊙		Payroll Processing	11,012		2,586	16	C.1.m
Point Click Care		○	⊙		Software User Fees	23,558		5,534	16	C.1.m
All Around		○	⊙		Snow Removal	16,036		12,164	22	C.6.f
Controlled Air		○	⊙		HVAC	7,129		5,408	22	C.6.f
Creative Financial Staffing		○	⊙		Temp Bookkeeper	20,689			16	C.1.m
EBM IT Services		○	⊙		Comuter server Admin	17,977		4,223	16	C.1.m
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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).

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22 Rev. 6/95

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	9/30/2018			22 | 37

Item		Total	CCNH	RHNS	Residential Care Home
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	29,766	16,926		12,840
b. Heat	$	28,904	16,436		12,468
c. Light & Power	$	107,707	61,246		46,461
d. Water	$	21,292	12,107		9,185
e. Equipment Lease (*Provide detail on page 6*)	$	785	446		339
f. Other (*itemize*)	$	144,332	84,578		59,754
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	332,786	191,739		141,047
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	17,086	9,716		7,370
b. Building & Building Improvements	$	289,860	164,825		125,035
c. Non-Movable Equipment	$	19,878	11,303		8,575
d. Movable Equipment	$	73,009	41,516		31,493
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	399,833	227,360		172,473
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	$	17	10		7
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	407,797	231,889		175,908

* 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	$ 1,079		$ 818
Purch Service - HVAC	$ 7,129		$ 5,408
Purchased Services - Electric	$ 1,721		$ 1,306
Purch Serv - Exterminator	$ 2,123		$ 1,610
Purchased Serv - Alarm Service	$ 997		$ 756
Purch Service - Fire Protecti	$ 5,277		$ 4,003
Purch Serv - Sec camera Main	$ 2,519		$ 1,911
Purch Service - Ridgefield As	$ 4,777		$ 3,623
Purch Service - Elevator	$ 2,227		$ 1,690
Purchased Service - Locksmith	$ 82		$ 63
Purch Service - Telephone Rep	$ 2,769		$ 2,101
Purchased Service - Fire Cont	$ 739		$ 561
Purchased Service - Shredding	$ 3,726		$ -
Purchased Service - Generator	$ 2,485		$ 1,885
Purch Serv - Snow Removal	$ 16,036		$ 12,164
Purch Service - Med Equip Ins	$ 779		$ 591
Purch Services - Legionella Rist Ass	$ 1,251		$ 949
Trash Removal- Maint	$ 4,442		$ 3,369
Medical Waste Removal	$ 2,080		$ -
Landscaping	$ 13,163		$ 9,985
Office Equip Maint Agreements	$ 9,177		$ 6,961
Total Other Repairs and Maintenance	$ 84,578	$ -	$ 59,754

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-23 Rev. 10/2006

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2018	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	206,486		206,487	51,066	SL	Var	13,777	
2. Disposals (attach schedule)					SL	Var		
3. Acquired during this report period (attach schedule)	99,283		99,283		SL	Var	3,309	
A-4. Subtotal								17,086
B. **Building and Building Improvements**								
1. Acquired prior to this report period	8,003,553		8,003,553	3,210,694	SL	Var	288,415	
2. Disposals (attach schedule)					SL	Var		
3. Acquired during this report period (attach schedule)	58,748		58,748		SL	Var	1,445	
B-4. Subtotal								289,860
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	328,630		328,630	119,818	SL	Var	19,878	
2. Disposals (attach schedule)					SL	Var		
3. Acquired during this report period (attach schedule)					SL	Var		
C-4. Subtotal								19,878

	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	SL	5		
b.	x		8	2017	68,717		68,717	12,407	SL	6	11,453	
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					593,494		593,494	267,680	SL	Var	56,990	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					59,955		59,955		SL	Var	4,566	
D-3. Subtotal												73,009
E. ***Total Depreciation***												399,833

Leeway, Inc.
9/30/2018

Schedule of Land Improvements Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/1/2017	Catherine Kennedy Memorial Garden - Simple Solutions	$ 73,768	15	$ 2,459	
5/18/2018	Fence for Parking Lot - Walsh Fence	$ 18,715	15	$ 624	
5/22/2018	Electrical lighting for Garden Area (State Street) - Mace Company	$ 3,400	15	$ 113	
6/20/2018	Electrical for Gate @ Parking Lot - Mace Company	$ 3,400	15	$ 113	
Total additions for Land Improvement		$ 99,283		$ 3,309	*
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:					
10/30/2017	Basement Sprinkler system replaced - Fire Protection Testing	$ 2,246	25	$ 45	
1/25/2018	Install Window in office - BSC Services LLC	$ 2,985	15	$ 100	
2/16/2018	Fire Door repair - Facilities Compliance Services	$ 4,800	15	$ 80	
6/11/2018	Install Shunt Trip breakers for HVAC - Mace Company	$ 12,875	20	$ 322	
9/30/2018	Room 1 SNF Renovations - All-Around Home Impr/HD/All American Waste	$ 1,315	20	$ 33	
9/30/2018	Room 3 SNF Renovations - All-Around Home Impr/HD/All American Waste	$ 2,558	20	$ 64	
9/30/2018	Room 4 SNF Renovations - All-Around Home Impr/HD/All American Waste	$ 707	20	$ 18	
9/30/2018	Room 5 SNF Renovations - All-Around Home Impr/HD/All American Waste	$ 846	20	$ 21	
9/30/2018	Room 6 SNF Renovations - All-Around Home Impr/HD/All American Waste	$ 1,196	20	$ 30	
9/30/2018	Room 7 SNF Renovations - All-Around Home Impr/HD/All American Waste	$ 2,122	20	$ 53	
9/30/2018	Room 8 SNF Renovations - All-Around Home Impr/HD/All American Waste	$ 1,233	20	$ 31	
9/30/2018	Room 13 SNF Renovations - All-Around Home Impr/HD/All American Waste	$ 2,343	20	$ 59	
9/30/2018	Room 14 SNF Renovations - All-Around Home Impr/HD/All American Waste	$ 2,261	20	$ 57	
9/30/2018	Room 15 SNF Renovations - All-Around Home Impr/HD/All American Waste	$ 191	20	$ 5	
9/30/2018	Room 16 SNF Renovations - All-Around Home Impr/HD/All American Waste	$ 1,040	20	$ 26	
9/30/2018	Room 17 SNF Renovations - All-Around Home Impr/HD/All American Waste	$ 90	20	$ 2	
9/30/2018	Room 19 SNF Renovations - All-Around Home Impr/HD/All American Waste	$ 1,888	20	$ 47	
9/30/2018	Room 20 SNF Renovations - All-Around Home Impr/HD/All American Waste	$ 1,302	20	$ 33	
9/30/2018	Room 21 SNF Renovations - All-Around Home Impr/HD/All American Waste	$ 923	20	$ 23	
9/30/2018	Room 24 SNF Renovations - All-Around Home Impr/HD/All American Waste	$ 1,013	20	$ 25	
9/30/2018	Room 26 SNF Renovations - All-Around Home Impr/HD/All American Waste	$ 1,756	20	$ 44	
9/30/2018	Room 27 SNF Renovations - All-Around Home Impr/HD/All American Waste	$ 991	20	$ 25	
9/30/2018	Room 28 SNF Renovations - All-Around Home Impr/HD/All American Waste	$ 341	20	$ 9	
9/30/2018	Room 29 SNF Renovations - All-Around Home Impr/HD/All American Waste	$ 2,131	20	$ 53	
9/23/2018	Office are renovation - BSC Services LLC	$ 9,595	20	$ 240	
Total additions for Building Improvement		$ 58,748		$ 1,445	*
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

			Useful		
Acquisition Date	**Description of Item**	**Cost**	**Life**	**Depreciation**	

Attachment Pages 23 24

Acquisition Date	Description of Item	Cost	Life	Depreciation	
Additions:					
Total additions for Non-Movable Equipment		$ -		$ -	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

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

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

Schedule of Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
11/22/2017	Mailboxes - Goody's	$ 1,100	15	$ 37	
12/4/2017	Sony TV & Mount for Recreation - P. C. Richard & Son	$ 2,380	5	$ 238	
1/5/2018	Office Furniture for ED - Raymour & Flanigan & Pier One & Overstock	$ 9,540	20	$ 239	
1/19/2018	Mailboxes for Mail Room - Amazon.com	$ 2,560	15	$ 85	
2/23/2018	New Recorder in Camera Installed - Tyco Intergrated Security	$ 3,025	5	$ 303	
3/1/2018	Bulletin Board Cabinet for Disaster Planning - North Sculpture Co.	$ 2,090	15	$ 70	
5/21/2018	Cots for Disaster Planning - McKesson	$ 3,622	10	$ 181	
5/25/2018	Patio Umbrellas - Bakker Specialty	$ 5,064	5	$ 506	
6/8/2018	Plate warmer for kitchen - Globe Equipment	$ 2,097	10	$ 105	
6/25/2018	15 Foam Mattresses - McKesson	$ 6,633	5	$ 663	
5/15/2018	Washer & Dryer - Yankee Equipment Systems	$ 3,350	10	$ 168	
8/8/2018	7 Dell Dek top computers	$ 5,125	3	$ 854	
9/10/2018	PA Sound System, Microphones, stnads, cable & Cases for Recreation	$ 3,576	5	$ 358	
9/21/2018	Replace Freezer Compressor - Appollo Refrigeration	$ 6,850	5	$ 685	
1/30/2018	Office Furniture - United Office Furniture	$ 2,943	20	$ 74	
Total additions for Movable Equipmen		$ 59,955		$ 4,566	*
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 Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Leasehold Improvemer		$ -		$ -	*
Deletions:					
Total deletions for Leasehold Improvemer		$ -		$ -	**

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2018	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 _-Mortga	12	2014	15	20,361	5,599	S/L		2,036	
2. Financing Costs Key Bank _-Mortga	12	2014	20	59,107	10,344	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-25 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2018	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%	500.00%		
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 _____	553,324	2,977,563		
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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-26 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Leeway, Inc.	2167-C	9/30/2018	26 | 37

Item		Total	CCNH	RHNS	Residential Care Home
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$	29,200	16,604		12,596
Name of Lender: Key Bank	Rate: Variable				
Address of Lender					
2. Second Mortgage	$	170,034	96,688		73,346
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)	$	199,234	113,292		85,942

(*Carry Subtotals forward to next page*)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-27 Rev. 6/95

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	9/30/2018	27 | 37

Item				Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:				199,234	113,292		85,942
12. C. Movable Equipment							
1. Automotive Equipment			$	2,224	1,265		959
A. Item	Rate	Amount					
Bus / Van							
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)			$	2,224	1,265		959
12. D. Other Interest Expense (*Specify*)			$	239	136		103
Working Capital Loans							
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)			$	201,697	114,693		87,004
14. Insurance							
a. Insurance on Property (buildings only)			$	17,157	8,650		8,507
b. Insurance on Automobiles			$	8,317	4,193		4,124
c. Insurance other than Property (as specified above)							
1. Umbrella (*Blanket Coverage*)			$	19,825	15,026		4,799
2. Fire and Extended Coverage			$				
3. Other (*Specify*)			$	17,402	13,189		4,213
Fid. Bond, Cyber, D&O, Crime							
14d. ***Total Insurance Expenditures (14a + b + c)***			$	62,701	41,058		21,643
15. ***Total All Expenditures (A-13 thru C-14)***			$	6,715,292	5,038,450		1,676,842

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-28 Rev. 9/2002

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Leeway, Inc.	2167-C	9/30/2018	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.			Occupational Therapy $				
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $	42,455	42,455		
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15		Bad Debts $	44,056	22,210		21,846
10.	25		Accounting $				
10a.			Legal $	10	5		5
11.	15		Telephone $	2,383			2,383
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		Fund Raising / Contributions $	20,342	10,255		10,087
21.			Unallowable Management Fees $				
22.	16		Barber and Beauty $	455	229		226
23.			Other - See attached Schedule $	22,414	19,534		2,880
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $				
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	132,115	94,688		37,427

* 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
		Cable TV	$ 7,279		
		Penalties And Late Fees	$ 113		$ 27
		Lobbying Expenses	$ 9,717		$ 2,283
		Alumni Expenses	$ 126		$ 30
		Resident Personal Items	$ (103)		$ (24)
		Non-Reimburseable	$ 2,402		$ 564
		0			
		Note: Cable Tv Revenue disallowed			
Total Other A&G Adjustments			$ 19,534	$ -	$ 2,880

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-29 Rev. 10/2006

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

Name of Facility	License No.	Report for Year Ended	Page of
Leeway, Inc.	2167-C	9/30/2018	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
			Subtotals Brought Forward $	132,115	94,688		37,427
Page 20 - Resident Care Supplies***							
27.	20		Prescription Drugs $	123,982	123,982		
28.	20		Ambulance/Limousine $	501	501		
29.	20		X-rays, etc $	607	607		
30.	20		Laboratory $	12,949	12,949		
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 $				
45.			Management Fees Direct $				
46.			Management Fees Indirect $				
47.			Other - Direct $	11,974	2,632		9,342
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)***		$	282,128	235,359		46,769

*** 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

Leeway, Inc.
9/30/2018

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 Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
30		Telephone & Cable Revenue			$ 6,753
30		Misc Revenue	$ 2,118		$ 2,083
30		Restricted Recreation Donations	$ 514		$ 506
Total Other Adjustments			$ 2,632	$ -	$ 9,342

Schedule of Unallowable Building Interest

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-30 Rev.10/2005

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Leeway, Inc.	2167-C	9/30/2018	30 | 37

Item		Total	CCNH	RHNS	Residential Care Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	6,351,275	4,695,144		1,656,131
b. Medicaid Room and Board Contractual Allowance **	$	(630,164)	(527,879)		(102,285)
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	337,932	337,932		
b. Medicare Room and Board Contractual Allowance **	$	477,591	477,591		
4. a. Private-Pay Residents and Other	$	60,070			60,070
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	98,856	98,856		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(98,856)	(98,856)		
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	$	88,817	88,817		
b. Physical Therapy - Medicare Contractual Allowance **	$	(73,772)	(73,772)		
c. Physical Therapy - Non-Medicare	$	54,208	54,208		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(54,208)	(54,208)		
4. a. Speech Therapy - Medicare	$	48,174	48,174		
b. Speech Therapy - Medicare Contractual Allowance **	$	(23,035)	(23,035)		
c. Speech Therapy - Non-Medicare	$	23,288	23,288		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(23,288)	(23,288)		
5. a. Occupational Therapy - Medicare	$	68,562	68,562		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(55,766)	(55,766)		
c. Occupational Therapy - Non-Medicare	$	22,368	22,368		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(22,368)	(22,368)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	6,649,684	5,035,768		1,613,916
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$	2,383			2,383
4. Rental of Television and Cable Services	$	6,753			6,753
5. Interest Income *(Specify)*	$	1,313	662		651
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	89,029	45,185		43,844
V. Total Other Revenue (1 thru 8)	$	99,478	45,847		53,631
VI. Total All Revenue (III +V)	$	6,749,162	5,081,615		1,667,547

* *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
	Med A Lab	$ 10		
	Med A Radiology	$ 8,341		
	Medicare A Allowance	$ (8,351)		
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Resident Revenue		$ -	$ -	$ -

Interest Income

Page Ref	Account	Balance	CCNH	RHNS	Residential Care Home
	Money Market Account	202,910	$ 662		$ 651
Total Interest Income			$ 662	$ -	$ 651

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
	Misc. Revenue	$ 2,118		$ 2,083
	CLM Donations	$ 179		$ 176
	Fund Raiser-Annual Appeal	$ 3,494		$ 3,436
	Donations - Unrestricted	$ 19,576		$ 19,254
	Restricted Donations - Rec De	$ 816		$ 204
	Donations - United Way	$ 290		$ 286
	Brick Campaign	$ 18,712		$ 18,405
Total Other Revenue		$ 45,185	$ -	$ 43,844

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-31 Rev. 6/95

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2018	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 579,520
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 630,098
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 28,667
4 Inventories				$
5. Prepaid Expenses				$ 20,582
a.				
b.				
c.				
d. See Schedule		20,582		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,258,867
B. Fixed Assets				
1. Land				$ 581,784
2. Land Improvements	*Historical Cost	305,769		$ 237,617
	Accum. Depreciation	68,152	Net	
3. Buildings	*Historical Cost	8,062,301		$ 4,561,747
	Accum. Depreciation	3,500,554	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	328,630		$ 188,934
	Accum. Depreciation	139,696	Net	
6. Movable Equipment	*Historical Cost	653,449		$ 324,213
	Accum. Depreciation	329,236	Net	
7. Motor Vehicles	*Historical Cost	83,700		$ 44,857
	Accum. Depreciation	38,843	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 2,539,282
See Schedule		2,539,282		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 8,478,434

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

(*Carry Total forward to next page*)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-32 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2018	32	37

Account				Amount
			Total Brought Forward:	$ 9,737,301
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*)				$ 355,927
See Schedule		355,927		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 355,927
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 10,093,228

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

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
		Prepaid Insurance	$ 12,190
		Prepaid Dues	$ 1,346
		Prepaid Relias	$ 2,740
		Prepaid Time & Attendance	$ 1,043
		Prepaid DSS Copier	$ 1,968
		Prepaid Fire Alarm Maint	$ 1,295
Total Prepaid Expenses			$ 20,582

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 Depreciation - Non-Reimbursable	$ 2,537,822
		CIP _ Elevator	$ 1,460
Total Other Other Fixed Assets (Itemize)			$ 2,539,282

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Board Designated Fund	$ 300,349
		Deferred Financing Key Bank Mortgage #1	$ 20,361
		Deferred Financing Key Bank Mortgage #2	$ 59,107
		Accum Amortz - Deferred Fin #1	$ (7,635)
		Accum Amortz - Deferred Fin #2	$ (16,255)
Total Other Assets			$ 355,927

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
		Note Payable - UI	$ 44,489
Total Notes Payable			$ 44,489

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

Page Ref	Line Ref	Description	
		Due to Medicaid	$ 134,471
		Resident Trust	$ 11,072
		Accrued Provider tax	$ 55,430
		Deferred Income - DMHAS	44321
		Deferred Income - DSS Case Mgmt	377826
		Deferred Income - HOPWA	-14111
Total Other Current Liabilities (Itemize)			$ 609,009

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

Page Ref	Line Ref	Description	
		DSS Bond Advances	$ 2,175,000
		Mortgage Swap Liability	$ (5,845)
		Mortgage #2 Swap Liabiity	$ (56,896)
Total Other Current Liabilities (Itemize)			$ 2,112,259

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-33 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2018	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 251,477
	2. Notes Payable (*itemize*)				$ 44,489
	See Schedule		44,489		
	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*)				$ 148,639
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 9,319
	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*)				$ 609,009
			See Schedule	609,009	
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 1,062,933

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

(Carry Total forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-34 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2018	34	37

Account				Amount
			Total Brought Forward:	1,062,933
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (*itemize*)				$ 31,881
Name of Lender	Purpose	Amount	Date Due	
	Bus / Van	33,881	7/1/22	
2. Mortgages Payable				$ 3,530,887
3. Loans from Owners or Related Parties (*itemize*)				$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (*itemize*)				$ 2,112,259
See Schedule	2,112,259			
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ 5,675,027
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 6,737,960

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-35 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2018	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	$ 2,960,391
	6. Gain or Loss for Period 10/1/2017 thru 9/30/2018	$ 394,877
	7. Total Net Worth	$ 3,355,268
C.	***Total Reserves and Net Worth***	$ 3,355,268
D.	***Total Liabilities, Reserves, and Net Worth***	$ 10,093,228

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-36 Rev. 6/95

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2018	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2017			$ 2,443,212
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 6,749,162
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 6,715,292
D.	Net Income or Deficit			$ 394,877
E.	Balance			$ 2,477,082
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Grant , Housing & non-reimbursable Revenue		1,511,433	
	Grant , Housing & non-reimbursable Expense		(1,150,426)	
	2. Other (*itemize*)			
F-3.	Total Additions			$ 361,007
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***	09/30/18		$ 2,838,089

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	9/30/2018	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	
Addres Address	Phone Number
	941 303-3958
Annual Report Contact	Phone Number
Roland Beneke	203 865-0068
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