February 11, 2019

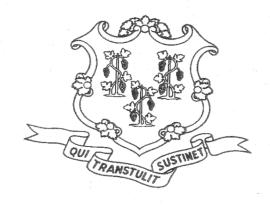
Mr. Chris LaVigne, Director Office of Reimbursement and CON Department of Social Services 55 Farmington Ave Hartford, CT 06105

Dear Chris:

Enclosed please find the 2018 Medicaid Cost Report for New Milford Crossings, LLC.

In preparing this cost report, we did not perform any disallowances for the administrator salary expense or dues expense in excess of the limits for each prescribed by your department. We also did not perform any disallowances related to physical therapy and speech therapy, which were paid for by entities other than the Medicaid Program. Further, we did not disallow any depreciation or interest expense in excess of amounts previously approved via Certificate of Need or related to any prior state desk review or field audits. We believe that these disallowances are performed by the software used by your department in the preparation of the facility's rate computation report, and we do not want to create an inadvertent duplication of disallowance by calculating these adjustments. We believe this preparation methodology is in compliance with any rules and regulations of your department and the federal government.

State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2018

Name of Facility (as I	,							
New Milford Crossin			Center for Heal	th and Rel	nabilitation			
Address (No. & Stree	et, City, State, Z	ip Code)						
19 Poplar Street, Nev	v Milford, CT 0	6776						
Type of Facility								
Chronic and Convalescent Nursing Home only (CCNH) Rest Home with Nursing Supervision only (RHNS)								
Report for Year Begin	nning		Report for Yea	r Ending				
10/1/2017			9/30/2018					
License Numbers: CCNH RHNS (Specify) Medicare Prov. 075208						dicare Provider 075208		
Medicaid Provider Nu	ımbers:		CNH	RH	INS		ICI	F-IID
		8771						
For Department Use	Only							
Sequence Number	Signed and	Date	Sequence N	lumber	Signed a	nd Notarize	d	Date Received
Assigned	Notarized	Received	Assign	ed	Signed a	nu motarizc	u	Date Received
							•	

Table of Contents

Gene	eral Information - Administrator's/Owner's Certification	1
Gene	eral Information and Questionnaire - Data Required for Real Wage Adjustment	1A
Gene	eral Information and Questionnaire - Type of Facility - Organization Structure	2
Gene	eral Information and Questionnaire - Partners/Members	3
Gene	eral Information and Questionnaire - Corporate Owners	3A
Gene	eral Information and Questionnaire - Individual Proprietorship	3B
Gene	eral Information and Questionnaire - Related Parties	4
Gene	eral Information and Questionnaire - Basis for Allocation of Costs	5
Gene	eral Information and Questionnaire - Leases	6
Gene	eral Information and Questionnaire - Accounting Basis	7
Sche	edule of Resident Statistics	8
Sche	edule of Resident Statistics (Cont'd)	9
A.	Report of Expenditures - Salaries & Wages	10
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant	
	Administrators and Other Relatives	11
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant	
	Administrators and Other Relatives (Cont'd)	12
B.	Report of Expenditures - Professional Fees	13
	Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee	
	for Service Basis	14
C.	Expenditures Other than Salaries - Administrative and General	15
C.	Expenditures Other than Salaries (Cont'd) - Administrative and General	16
	Schedule C-1 - Management Services	17
C. C.	Expenditures Other than Salaries (Cont'd) - Dietary	18
C.	Expenditures Other than Salaries (Cont'd) - Laundry	19
C.	Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
	Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C.	Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
	Depreciation Schedule	23
	Amortization Schedule	24
C.	Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C.	Expenditures Other than Salaries (Cont'd) - Interest	26
C.	Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D.	Adjustments to Statement of Expenditures	28
D.	Adjustments to Statement of Expenditures (Cont'd)	29
F.	Statement of Revenue	30
G.	Balance Sheet	31
G.	Balance Sheet (Cont'd)	32
G.	Balance Sheet (Cont'd)	33
G.	Balance Sheet (Cont'd)	34
G.	Balance Sheet (Cont'd) - Reserves and Net Worth	35
H.	Changes in Total Net Worth	36
I.	Preparer's/Reviewer's Certification	37

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
New Milford Crossings, LLC / DBA Village Crest Cer	2330	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 New Milford Crossings, LLC / DBA Village Crest Center for Health and Rehabilitation [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)			Printed Name (Owner)	
Erin Healy			Marvin J. Ostreicher	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires

Address of Notary Public

(Notary Seal)

State of Connecticut

Department of Social Services

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	Page	of		
	1A	37		
Name of Facility	From	То		
New Milford Crossings, LLC / DBA Village Crest Center for Hea	10/1/2017	9/30/2018		
Address of Facility				
19 Poplar Street, New Milford, CT 06776	ı			
Report Prepared By	Phone Num		Date	
Blum, Shapiro & Company, P.C.	203-944-21	.00	2/11/2019	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			1 37
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.

General Information and Questionnaire Type of Facility - Organization Structure

	Pho	ne No. of Fac	ility	Report for Ye	ar Ended	Page	(of
	203	-354-9365		9/30/2018		2	(*)	37
Name of Facility (as shown on license)		Address (No	o. & S	Street, City, Sto	ate, Zip)			
New Milford Crossings, LLC / DBA Village Crest Cente	r for	119 Poplar St	reet,	New Milford,	CT 06776	6		
CCNH		RHNS		(Specify)		Medicare F	rovid	er No.
License Numbers: 2330						075208		
Type of Facility (Check appropriate box(es))								
☐ Chronic and Convalescent Nursing Home only (CCNH)		t Home with l ervision only			(Specify)			
Type of Ownership (Check appropriate box)								
O Proprietorship O Partnership	0	Profit Corp.	0	Non-Profit Con	p. O	Government	0	Trust
If this facility opened or closed during report year provide	e:		Date	Opened	Date Clos	sed		
Has there been any change in ownership								
or operation during this report year?	0	Yes	•	No	If "Yes,"	explain full	y.	
Administrator								
Name of Administrator				Nursing Ho	ome			
James Noonan				Administrat	or's	001100		
				License 1	No.:			
Other Operators/Owners who are assistant administrators	s (ful	l or part time) of t					
Name				License 1	No.:			

CSP-3 Rev. 10/2005

General Information and Questionnaire Partners/Members

Name of Facility New Milford Crossings, LLC /		Report for \ 9/30/2018	Year Ended	Page 3	of 37	
Legal Name of Parts	Business A		State(s) and/o Which R	or Town((s) in	
New Milford Crossings, LLC / Center for Health and Rehabilit	DBA Village Crest	19 Poplar Street, Milford, CT 067				
Name of Partners/Members	ldress		Title	% Ow	vned	
See attachment						

New Milford Crossings, LLC Page 3 Attachment

Owner	Ownership Percentage
Agnes Zitter	2.083%
Albert David	1.667%
Barry Bokow	1.000%
BNB Healthcare Funds LLC	6.667%
Chaim Goldenberg	5.000%
David Cohen	6.667%
Gerald Neuman	3.333%
Ira Geffner	1.000%
Josef Skoczylas	2.000%
Tzivy Roberts	6.667%
Magda Manela	5.000%
Marvin J. Ostreicher	30.749%
Michael Lipman	5.000%
Mordechai Eisen	2.500%
Morris Fuchs	8.333%
Moshe Shaya-Mograby	1.667%
Nathan Pollack	4.167%
Shmuel Laufer	2.500%
Tali Skoczylas	4.000%
	100.000%

General Information and Questionnaire Corporate Owners

Name of Facility New Milford Crossings, LLC / DBA Village (License No. 2330	Report for Year End 9/30/2018	ded	Page 3A	of 37		
If this facility is owned or operated as a corpor		on:	ЗA	37			
Legal Name of Corporation		s Address	State(s) in Which Incorporated				
Zegari amie er eesperanen	2 45 111 5	211001000	(b) III ++ III		91410		
Name of Directors, Officers	Busines	Title	No. Sl Held by				
Names of Stockholders Owning at Least 10% of Shares							

CSP-3B Rev. 10/2005

General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Crossings, LLC / DBA Village Crest	2330	9/30/2018	3B	37
If this facility is owned or operated as an individual		vide the following information	:	
Ow	rner(s) of Facility			
	,			
			_	

General Information and Questionnaire Related Parties*

Name of Facility		License	e No.		Report for Year Ended		Page	of
New Milford Crossings,	LLC / DBA Village Crest Cent		2330		9/30/2018		4	37
	iving compensation from the fac	-		_		If "Yes," provide th		
marriage, ability to contr	ol, ownership, family or busines	ss assoc	iation?	0	Yes O No	complete the inform	nation on Pag	ge 11 of the report.
Are any individuals or co	ompanies which provide goods of	or servic	es,					
including the rental of pr	operty or the loaning of funds to	this fac	cility,					
related through family as	sociation, common ownership,	control,	or busin	ess	⊙ Yes O No			
association to any of the	owners, operators, or officials of	of this fa	cility?			If "Yes," provide th	e following	information:
		Als	so Provi	des		Indicate Where		
		Good	ds/Servi	ces to		Costs are Included		
Name of Related	Business	Non-I	Related 1		Description of Goods/Services	in Annual Report	Cost	Actual Cost to the
Individual or Company	Address	Yes	No	%**	Provided	Page # / Line #	Reported	Related Party
See attachment		0	•					
See attachment								
		0	•					
		0	•					
		0	•					
		0	•					
		0	•					
		0	•					
							 	
		0	•					
		0	•					

^{*} Use additional sheets if necessary.

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

CSP-4 Rev. 10/2005

General Information and Questionnaire Related Parties*

Name of Facility		License	No.		Report for Year Ended			Page	of
New Milford Crossings Ll	LC DBA Village Crest Center for								
Health and Rehabilitation			8771		9/30/2018			4	37
Are any individuals rece	eiving compensation from the fa	cility re	lated th	rough		If "Yes," p	provide the Name	Address an	d
marriage, ability to cont	rol, ownership, family or busine	ess assoc	ciation?	U	☐ Yes ☑ No	complete t	he information or	n Page 11 of	the report
- J	1, 3				_ 103 _ 110	complete t	ine information of	irage ir oi	ше тероге.
Are any individuals or c	companies which provide goods	or servi	ces,						
including the rental of n	roperty or the loaning of funds	to this fa	cility						
	ssociation, common ownership,			inecc					
	e owners, operators, or officials			111035	✓ Yes □ No	If "Vec " pr	ovide the following	r information	
association to any of the	towners, operators, or officials	or tills i	aciiity:		V Tes INO	ii i es, pi	ovide the following	g iiiioiiiiatioii	•
	T	A 1	so Provi	dos					
						Indicate 1	Where Costs are		Actual Cost to the
N CD 1 . 1			ls/Servi		D : : : : : : : : : : : : : : : : : : :			a .	
Name of Related	Business		Related		Description of Goods/Services		n Annual Report	Cost	Related
Individual or Company		Yes	No	%**	Provided	Pag	e # / Line #	Reported	Party
D C 1771 G 1	809 Main Street, East Hartford, CT	V		450/	DT OT STA : (G. IV	1.2	5 0 10 10	550.010	540.516
Preferred Therapy Solutions	06108 6851 Jericho Turnpike, Suite 150	Ŭ	ш	45%	PT, OT, ST Services/Consulting	13	5a, 9a, 10a, 12	559,910	548,716
NOA Diagnostics	Syosset, NY 11791	7		630/	Radiology	20	5f	7,592	7,091
National Health Care	850 Silas Deane Highway,			0370	Radiology	20	31	1,392	7,091
Associates - Aetna	Wethersfield, CT 06109		✓		Health Insurance	15	A5	496,739	496,739
	20 East Sunrise Highway, Valley							Í	ŕ
National Healthcare	Stream, NY 11581		>		Interest Expense	27	12d	2,647	2,647
	20 East Sunrise Highway, Valley	l							
National Healthcare	Stream, NY 11581		✓		Banking Transactions	16	m13	16,058	16,058
EP New Milford Acquisition	e .		V		DENT DE T	22	0	272.000	272.000
LLC	Wethersfield, Ct 06109 20 East Sunrise Highway, Valley				RENT/RE Taxes	22	9	372,000	372,000
National Healthcare	Stream, NY 11581		✓		Shared Expenses	16	m12	419,859	419,859
National Treatment	850 Silas Deane Highway,				Shared Expenses	10	III12	417,037	417,037
850 Silas Deane	Wethersfield, Ct 06109		✓		RENT/OTHER EXP.	16	m12	1,378	1,378
	20 East Sunrise Highway, Valley							Í	,
20 Sunrise	Stream, NY 11581		>		RENT/OTHER EXP.	16	m12	12,335	12,335
	20 East Sunrise Highway, Valley								
National Healthcare	Stream, NY 11581		V		Consulting Fees	16	m13	9,471	9,471
Procare LTC Pharmacy of	1492 Highland Avenue, Cheshire,	✓			D (0.1.10 1) (0.1.10 1)	20	5 01 / D10 - 5	154 405	1.40.000
CT Procare LTC Pharmacy Of	CT 06410 155 Northboro Road, STE 4,			73%	Drugs/Otc's/Supplies/Consult/Med Record	20	5a2b/c, B12, m5	154,402	143,938
MA LLC		V		730/	Drugs/Otc's/Supplies/Consult/Med Record	20	5a2b/c, B12, m5	9,430	8,791
IVIA LLC	Southborough, MA 01772	. –		1370	Thrugs One staupplies/Collsult/Med Record	20	Ja20/C, D12, IIIJ	7,430	0,/91

^{*} Use additional sheets if necessary.

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

*** Consolidated for all National Healthcare CT Facilities, control and ownership pass upon transfer of funds to insurance company manager. Information required by previous state auditor.

CSP-4 Rev. 10/2005

General Information and Questionnaire Related Parties*

Name of Facility New Milford Crossings LLC	C DBA Village Crest Center for Health and Rehabilitation	License 8771	No.		Report for Year Ended 9/30/2018			Page 4	of 37
,	ring compensation from the facility related through l, ownership, family or business association?				☐ Yes ☑ No	/ 1	provide the Name/ the information on		e report.
including the rental of pro related through family ass	mpanies which provide goods or services, perty or the loaning of funds to this facility, ociation, common ownership, control, or business owners, operators, or officials of this facility?				✓ Yes □ No	If "Yes," pr	rovide the following	; information:	
Name of Related Individual or Company	Business Address	Good	so Provi ds/Servi Related I No	ces to	Description of Goods/Services Provided	Included	Where Costs are in Annual Report ge # / Line #	Cost Reported	Actual Cost to the Related Party
National Health Care Associates - Aetna	850 Silas Deane Highway, Wethersfield, CT 06109		7		Accounts payable	33	A1	150,059	150,059
EP New Milford Realty, LLC	850 Silas Deane Hwy, Wethersfield, Ct 06109		7		Due to Realty	33	A12	489,521	489,521
Bristol Crossings LLC	61 Bellevue Ave, Bristol, CT 06010		7		Due to Related	33	A12	15,639	15,639
Preferred Therapy Solutions	850 Silas Deane Highway, Wethersfield, CT 06109	V		45%	Due to Related	33	A12	123,915	123,915
NOA Diagnostics The Pines at Poughkeepsie Center for Nursing and	6851 Jericho Turnpike, Suite 150 Syosset, NY 11791 100 Franklin Street, Poughkeepsie, NY 12601	✓			Due to Related Due to Related	33	A12	2,086 20,817	2,086 20,817
National Health Care	20 East Sunrise Highway, Valley Stream, NY 11581		V		Due to Related (Debt)	33/34	A12/B4	97,634	97,634
	20 East Sunrise Highway, Valley Stream, NY 11581		V		Due to Related	33	A12	56,097	56,097
Procare LTC Pharmacy of CT Milford Health Care Center.	1492 Highland Ave Cheshire CT 06410			73%	Due to Related	33	A12	40,495	40,495
,	195 Platt Street, Milford, CT 06460		✓		Due to Related	33	A12	10,813	10,813

^{*} Use additional sheets if necessary.

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

*** Consolidated for all National Healthcare CT Facilities, control and ownership pass upon transfer of funds to insurance company manager. Information required by previous state auditor.

CSP-5 Rev. 9/2002

General Information and Questionnaire Basis for Allocation of Costs

Name of Facility	License No	cense No. Report for Year Ended Page of							
New Milford Crossings, LLC / DBA Village Cre	2330		9/30/2018	5 37					
If the facility is licensed as CDH and/or RCH or	provides All	DS or TBI s	ervices with special Medicaid	rates, costs					
must be allocated to CCNH and RHNS as follow	rs:		_						
Item			Method of Allocation	n					
Dietary		Number of	meals served to residents						
Laundry		Number of	pounds processed						
Housekeeping		Number of	square feet serviced						
		Number of hours of routine care provided by EACH							
Nursing		employee o	classification, i.e., Director (or	Charge Nurse),					
		Registered	Nurses, Licensed Practical Nu	urses, Aides and					
		Attendants							
Direct Resident Care Consultants		Number of	hours of resident care provide	ed by EACH					
		specialist	(See listing page 13)						
Maintenance and operation of plant		Square fee							
Property costs (depreciation)		Square fee							
Employee health and welfare		Gross salar							
Management services			e cost center involved						
All other General Administrative expenses			rect and Allocated Costs						
The preparer of this report must answer the follow	wing questic	ons applicab	le to the cost information prov	vided.					
1. In the preparation of this Report, were all	• Yes	O No	If "No," explain fully why su	ch allocation was not					
costs allocated as required?	O 103	0 110	made.						
2. Explain the allocation of related company exp			11 1 11						
Shared expenses allocated by bed size and geogra	aphical locat	tion. See pag	ge 17 attachment.						
3. Did the Facility appropriately allocate and self			•	ne cost centers?					
(e.g., Assisted Living, Home Health, Outpatie	nt Services,	Adult Day	Care Services, etc.)						
	• Yes	O No	If "No," explain fully why su	ch allocation was not					
	O ICS	0 110	made.						
N/A									

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 Y	ear Ended		Page	of
New Milford Crossings, LLC / DBA Village	Crest C	enter fo	2330	9/30/2018	1		6	37
	Relate	ed * to						
	Owı	ners,						
	Operators,					Annual		
		icers		Date of	Term of	Amount		ount
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	of Lease	Clai	med
Reliable Health Systems - Nostrand Avenue, Brooklyn, NY 11230	0	•	Computer Equipment	10/01/08	60 / ongoing	3,178	3,178	
Wescom Solutions - P.O. Box 674802, Detroit, MI 48267	0	•	Software	Ongoing	Ongoing	22,688	22,688	
CIT Finance, LLC - 10201 Centurion Parkway N.#100 Jacksonville, FL 32256	0	•	Copier	07/21/15	39 months	4,997	4,997	
De Lage Landen - #501862 P.O. Box 41602, Philadelphia, PA, 19101	0	•	Copier	11/30/16	36 months	3,394	3,394	
	0	•						
	0	•						
	0	•						
	0	•						
	0	•						
	0	•						
Is a Mileage Log Book Maintained for All Le	ased Ve	hicles ?	O Yes	•	No	Total ***	34.256	

Is a Mileage Log Book Maintained for All Leased Vehicles?

^{*} 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.

CSP-7 Rev. 6/95

General Information and Questionnaire Accounting Basis

Name of Facility	License No.	Report for Year Ended		Page	of
New Milford Crossings, LLC / DB	2330	9/30/2018		7	37
The records of this facility for the p	period covered by this report v	were maintained on the following basis:			
	Modified Cash				
Is the accounting basis for this					
1	Yes	If "No," explain.			
previous period?	No				
Independent Accounting Firm					
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)			
1 Blum, Shapiro & Company, P.	C.	2 Enterprise Drive, Shelton, CT 06484			
2					
3					
4					
Services Provided by This Firm (de	escribe fully)				
1 Review, preparation of Medicare and	Medicaid cost reports, and year end	tax services.	\$	30,590	
2			\$		
3			\$		
4			\$		
			Charge for	r Services Pr	ovided
			\$	30,590	
Are These Charges Reflected in the Expend	liture Portion of This Report? If Yes	s, Specify Expense Classification and Line No.	Ψ	30,370	
	Page 15, line 1d	, i J i			
Legal Services Information	1 0 /				
Name of Legal Firm or Independen	t Attorney		Telephone	Number	
1 Goldman Gruder & Wood	,		_	3900 Ext. 00	00
2 Corporation Service Company			800-927-9	800	
3 Rogin Nassau, LLC			860-256-6	300	
4 Marshal Tim Poeti					
5 Corbett Suzann					
Address (No. & Street, City, State,	Zip Code)				
1 200 Connecticut Avenue, Norv	valk, CT				
2 251 Little Falls Drive, Wilmin					
3 185 Asylum Street - 22nd Floo	or, Hartford, CT 06103-3460				
4 5					
Services Provided by This Firm (de	escribe fully)				
1 Collections - Disallowed			\$	7,565	
2 Statuatory Representation - Disallowe	ed		\$	147	
3 Divestiture - Disallowed			\$	1,889	
4 Conservator - Disallowed			\$	(110)	
5 Conservator - Disallowed			\$	50	
			Charge for	r Services Pr	ovided
			\$	9,541	
Are These Charges Reflected in the Expend • Yes • No	liture Portion of This Report? If Yes Page 15, line 1e	s, Specify Expense Classification and Line No.		- /	

Schedule of Resident Statistics

Name of Facility							Report for Year Ended				Page	of
New Milford Crossings, LLC / DBA Village Crest C	enter for I	Health and	2	330			9/30/2013	8			8	37
]	Period 10	/1 Thru 6/	30		Period 7/	1 Thru 9/3	30
		Total	Total									
	Total All	CCNH	RHNS	Total	T . 4 . 1	CCMII	DING	(C:6-)	T-4-1	CCMII	DING	(C
	Levels	Level	Level	(Specify)	Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
Certified Bed Capacity A. On last day of PREVIOUS report period	0.5	0.5			0.5	0.5			0.5	0.5		
• • • • • • • • • • • • • • • • • • • •	95	95			95	95			95	95		
B. On last day of THIS report period 2. Number of Residents	95	95			95	95			95	95		
A. As of midnight of PREVIOUS report period	77	77			77	77			79	79		
B. As of midnight of THIS report period	74	74			79	79			74	74		
3. Total Number of Days Care Provided During Period		7-1			17	- 17			7-1	7-1		
A. Medicare	3,414	3,414			2,447	2,447			967	967		
B. Medicaid (Conn.)	22,399	22,399			17,021	17,021			5,378	5,378		
C. Medicaid (other states)												
D. Private Pay	1,816	1,816			1,194	1,194			622	622		
E. State SSI for RCH												
F. Other (Specify) Managed Care	288	288			218	218			70	70		
G. Total Care Days During Period (3A thru F)	27,917	27,917			20,880	20,880			7,037	7,037		
Total Number of Days Not Included in Figures in 4. 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)	27,917	27,917			20,880	20,880			7,037	7,037		

CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Faci	lity			Licer	ise No.				Report for Year Ended				Page of		
New Milford	Crossing	gs, LLC	/ DBA Village		2330				_	9/30/201	8		9	37	
				•				<u> </u>							
4. Were the	ere any c	hanges	in the certified b	ed ca	pacity du	ring th	ne repo	rt year	?	0	Yes	•	No		
If "YES"	', provid	e the fol	lowing informat	ion:											
		Place of	Change		Cl	nange	in Bed	s		Ca	pacity Afte	er Change			
Date of	CCNH	RHNS	(Specify)		Lost		(Gaine	1						
CI.															
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	Reason fo	or Change	
5 IC41		.1 :			ــــــــــــــــــــــــــــــــــــــ	41	4	(. 1 : :4	4 -1)		1		
	-	-	n certified bed o	-	-	tne re	port ye	ar (as	reporte	ea in item	4 above) p	provide the num	ber of		
RESIDE	ENT DA	YS for 9	0 days followin	g the o	change.					_			T		
			Change in R	esider	nt Days					CC	CNH	RHNS	(Spe	cify)	
1st change															
2nd chan	_														
3rd chan															
4th chan			1.5		20 00										
6. Number	of Resid	lents and	Rates on Septe	mber			ır	ı —			10 D		0.1 0.		
		=	Medicare		Medi	caid				Se	elf-Pay		Other Sta	te Assisted	
	Item		CCNH	C	CNH	RI	INS	CC	CNH	RI	INS	(Specify)	R.C.H.	ICF-MR	
No. of R			9		60				5						
Per Dien															
a. One b			PPS		233.70				425/480						
b. Two			PPS		233.70				390/450						
c. Three															
bed 1	rms.		PPS						355/405						
7 T . 1N	1 (· D1 · ·	1 TT - T - 4							TO	TAI	COMI	DIDIC	(G :C)	
		re - Part	l Therapy Treat	ments						10	TAL	CCNH	RHNS	(Specify)	
			usive of Part B)								3,905	3,905			
			e Treatments												
			Treatments								547	547			
C.	Other	ioruir v c	Treatments								10,320	10,320			
		Physical	Therapy Treatn	nents							14,772	14,772			
			Therapy Treatm												
		re - Part									399	399			
B.	Medica	id (Excl	usive of Part B)												
			e Treatments												
	2. Rest	torative '	Treatments								43	43			
	Other	-			-						622	622	-	-	
			herapy Treatm								1,064	1,064			
			tional Therapy T	Γreatn	nents										
		re - Part									2,023	2,023			
B.			usive of Part B)												
			e Treatments												
~		torative	Treatments								507	507			
	Other Total () a a u = - 4 !	on al Therene 7	lunct.							9,419	9,419			
D.	ıvıaı C	rccиран	onal Therapy T	reutm	enis					Ì	11,949	11,949			

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Report of Ex	penditures	- Salarie	es & wag	es		
Name of Facility	License No.		Report for Year	Ended	Page	of
New Milford Crossings, LLC / DBA Village Crest Center for	2330		9/30/2018		10	37
Are time records maintained by all individuals receiving com	pensation?	•	Yes	0	No	
·			Total Cost a	and Hours		
			Total Cost t	ina rrours		
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I		51				
of Schedule A1) 2. Administrator(s) (Complete also Sec. III		51				
of Schedule A1)	130,857	2,080				
3. Assistant Administrator (Complete also Sec. IV	130,037	2,000				
of Schedule A1)						
4. Other Administrative Salaries (telephone						
operator, clerks, receptionists, etc.)	153,004	8,208				
5. Dietary Service	22.404	(1)				
a. Head Dietitian b. Food Service Supervisor	23,494 52,907	2,235				
c. Dietary Workers	272,626	18,192				
6. Housekeeping Service						
a. Head Housekeeper	42,318	1,728				
b. Other Housekeeping Workers	210,295	14,258				
7. Repairs & Maintenance Services a. Engineer or Chief of Maintenance	53,718	2,112				
b. Other Maintenance Workers	686	105				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers 9. Barber and Beautician Services	81,939	5,783				
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	137,777	2,737				
b. RN 1. Direct Care	371,506	9,928				
2. Administrative**	152,648	3,464				
c. LPN						
1. Direct Care	815,474	31,057				
2. Administrative**	062.010	60.947				
d. Aides and Attendants e. Physical Therapists	962,010	60,847				
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	90,954	4,962				
i. Physicians						
Medical Director Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists l. Podiatrists						
m. Social Workers/Case Management	125,151	4,686				
n. Marketing	120,101	.,000				
o. Other (Specify)						
See Attached Schedule	2 (77 2)	172 0 / 0				
A-13. Total Salary Expenditures	3,677,364	173,049				

^{*} 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)

	CC	NH	RH	INS	(Specify)		
Position	\$	Hours	\$	Hours	\$	Hours	
Total	\$ -	-	\$ -	-	\$ -	-	

Schedule of Other Fees (Page 13)

	CC	NH	RH	NS	(Specify)		
Service	\$	Hours	\$	Hours	\$	Hours	
Consulting Fees - Nursing	\$ 2,879	Disallowed					
Consulting Fees - Rehabilitation Therapy and Ancillary	\$ 6,580	Disallowed					
Total	\$ 9,459	Disallowed	\$ -	-	\$ -	-	

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
New Milford Crossings, LLC / DBA	Village Cr	est Center fo	r Health and	2330		9/30/2018			11	37
		Salary Paid		Fringe Benefits and/or Other Payments	Full Description of	Total Hours	Line Where Claimed on	Name and Address of All	Total Hours	Compensation
Name	CCNH	RHNS	(Specify)	(describe fully)	Services Rendered	Worked	Page 10	Other Employment**	Worked	Received
Section I - Operators/Owners										
Marvin J. Ostreicher, 184 Wildacre Avenue, Lawrence, NY 11559				Same as employees	Supervises operations, deals with DNS & other	51	Page 16, 1m1	See attached		
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.

MARVIN J. OSTREICHER- OWNER TIME STUDY YEAR END SEPTEMBER 30, 2018

	BEDS	Total w/ Baft
Accepta		Total w/ Bnft
Augusta	72 102	45.19
Belair	102	50.90
Bethel	161	57.21
Bloomfield	120	53.32
Brattleboro	80	47.05
Brentwood	78	45.83
Brewer	111	53.11
Bristol	132	52.61
Cambridge	160	60.60
Catskill	136	55.04
Colony	92	51.58
Country	111	56.86
Dover	112	53.47
Eastside	69	46.37
Eliot	114	53.93
Glen Falls	120	53.32
Huntington	320	72.22
Kennebunk	78	50.58
Hebrew Home	257	75.23
Ludlowe	144	57.39
Maple View	120	52.32
Marlborough	120	50.32
Maywood	120	57.57
Milford	120	51.07
Newton Wellseley	110	51.76
Norway	70	46.23
Poughkeepsie	200	59.88
Regency	130	50.89
Reservoir	144	65.64
Riverside	345	74.64
Rutland	125	51.36
Sachem	111	49.36
Sands Point	180	61.74
Utica	117	46.00
Village Crest	95	51.40
Water's Edge	150	57.53
Westgate	104	49.61
Winship	72	45.44
Total	5,002	2,064.62

Vacation Sick Personal Holiday

Total

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 Y	ear Ended		Page	of
New Milford Crossings, LLC / DB	A Village C	Crest Center	for Health a	2330		9/30/2018			12	37
		Salary Pai	d	Fringe Benefits						
				and/or Other	Full Description of	Total Hours	Line Where Claimed on	Name and Address of All	Total Hours	C
Name	CCNH	RHNS	(Specify)	Payments (describe fully)	Full Description of Services Rendered	Worked	Page 10	Other Employment**	Worked	Compensation Received
Section III - Administrators***										
	1200-			Same as	Management & supervision of		_			
James Noonan	130,857			employees	healthcare	2,080	a2			
Section IV - Assistant Administrators										

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

^{**} Include <u>all</u> other employment worked during the cost year.

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

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

B. Report of Ex	_	res - Proi				
Name of Facility	License No.	• •	Report for Year Ended		Page	of
New Milford Crossings, LLC / DBA Village Crest (13	37		
		1	Total Cost	and Hours	Ī	
Itom	CCMH	Полия	DIING	Полия	(Smaaify)	Полия
*B. Direct care consultants paid on a fee	CCNH	Hours	RHNS	Hours	(Specify)	Hours
for service basis in lieu of salary						
(For all such services complete Schedule B1)						
Dietitian						
2. Dentist	6,531	Disallowed				
3. Pharmacist	10,744	Disallowed				
4. Podiatrist	10,711	Bisano wea				
5. Physical Therapy						
a. Resident Care	283,573	4,525				
b. Other		1,020				
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	57,300	246				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee						
(Quarterly meetings)						
Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee						
(Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	48,163	687				
b. Other						
10. Occupational Therapist						
a. Resident Care	222,714	3,847				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	78,388	1,063				
2. Administrative***						
b. LPN						
1. Direct Care	9,121	183				
2. Administrative***						
c. Aides	41,707	1,334				
d. Other						
12. Other (Specify)						
See Attached Schedule		Disallowed				
B-13 Total Fees Paid in Lieu of Salaries	767,700	11,885				

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

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

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

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

Name of Facility New Milford Crossings, LLC / DBA Villa	License No. ge Crest Cente 2330		Report for Y 9/30/2018	Year Ended	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Operato	* to Owners, ors, Officers	Expla	nation of Rela	tionship
Gerident Solutions - P.O. Box 290539, Wethersfield, CT 06129	Dentist	Yes	No •			
Procare LTC of CT - 111 Executive Boulevard, Farmingdale, NY 11735	Pharmacist, Consulting - Nursing	•	0	Common Own	ership	
Preferred Therapy - 850 Silas Deane Highway, Wethersfield, CT 06109	PT, OT, ST, Consulting Ther. & Ancill.	•	0	Common Own	ership	
Dr. John Beck - 50 Bridge Street, New Milford, CT 06776	Medical Director	0	•			
Dr. John Mullen - 131 Kent Road, New Milford, CT 06776	Medical Director	0	•			
SDX/Swallowing Diagnostics - P.O. Box 484, Avon, CT 06001	Speech Therapy	0	•			
MassTex Imaging, LLC - 3 Electronics Avenue, #201, Danvers, MA 01923-1099	Speech Therapy	0	•			
360 Healthcare Staffing, LLC - P.O. Box 674009, Dallas, TX 75267-4009	RN's	0	•			
AAA Nursing Care - 3303 Main Street, Stratford, CT 06614	RN's & LPN's	0	•			
Preferred Professional Service - 850 Silas Deane Highway, Wethersfield, CT 06109	CNA's	0	•			
The Nurse Network - 653 Main Street, Plantsville, CT 06479	RN's & LPN's	0	•			
Geron Nursing Northwest, Inc P.O. Box 552, New Milford, CT 06776	RN's & LPN's	0	•			
		0	•			
		0	•			
		0	•			
		0	•			
		0	•			
		0	•			
		0	•			
		0	•			
		0	•			
		0	•			

^{*} Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility License No.	Report for Ye	ear Ended	Page	of
New Milford Crossings, LLC / DBA Village Cres 2330	9/30/2018		15	37
<u> </u>				
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 250,440	250,440		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 69,658	69,658		
4. Social Security (F.I.C.A.)	\$ 275,958	275,958		
5. Health Insurance	\$ 496,739	496,739		
6. Life Insurance (employees only)				
(not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory)	\$ 8,226	8,226		
(not-owners and not-operators)				
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>)	\$			
See Attached Schedule				
b. Personal Retirement Plans, Pensions, and	\$			
Profit Sharing Plans for Owners and				
Operators (Discriminatory)*				
c. Bad Debts*	\$			
d. Accounting and Auditing	\$ 30,590	30,590		
e. Legal (Services should be fully described on Page 7)	\$ 9,541	9,541		
f. Insurance on Lives of Owners and	\$			
Operators (Specify)*				
g. Office Supplies	\$ 10,576	10,576		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 35,725	35,725		
2. Cellular Phones	\$ 1,768	1,768		
i. Appraisal (Specify purpose and	\$			
attach copy)*				
j. Corporation Business Taxes (franchise tax)	\$ 1,115	1,115		
k. Other Taxes (Not related to property - See Page 22)				
1. Income*	\$			
2. Other (Specify)	\$			
See Attached Schedule				
3. Resident Day User Fee	\$ 515,053	515,053		
Subtotal	\$ 1,705,389	1,705,389		

^{*} 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

New Milford Crossings, LLC / DBA Village Crest Center for Health and Rehabilitati Attachment Page 15 $9/30/2018\,$

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

.....

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

Name of Facility License N	0.	Report for Y	ear Ended	Page	of
New Milford Crossings, LLC / DBA Village Crest Cen 233		9/30/2018		16	37
87				-	
Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought	Forward:	1,705,389	1,705,389	Turio	(Specify)
Travel and Entertainment	101//01/01	1,700,000	1,700,000		
Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	686	686		
3. Gifts to Staff and Residents	\$	2,245	2,245		
4. Employee Travel	\$	2,988	2,988		
5. Education Expenses Related to Seminars and Convention		835	835		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$	512	512		
7. Other (<i>Specify</i>)	\$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (all such expenses)	\$				
2. Advertising Telephone Directory (all such expenses)*	** \$				
3. Advertising Other (Specify)***	\$	19,659	19,659		
See Attached Schedule					
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied	\$				
directly and not by contract or fee for service)***					
7. Postage	\$	2,493	2,493		
* 8. Dues and Membership Fees to Professional	\$	7,588	7,588		
Associations (Specify)					
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org	g.*** \$	280	280		
9. Subscriptions	\$	6,900	6,900		
10. Contributions***	\$	675	675		
See Attached Schedule					
11. Services Provided by Contract (Specify and Complete	\$				
Schedule C-2, Page 21 for each firm or individual)					
12. Administrative Management Services**	\$	433,572	433,572		
13. Other (<i>Specify</i>)	\$	285,497	285,497		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	\$	2,469,319	2,469,319		

^{*} Do not include Subscriptions, which should go in item 9.

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Advertising Promotional - Marketing - Disallowed	\$ 14,883		
Advertising Promotional - Administration - Disallowed	\$ 4,776		
Total Other Advertising	\$ 19,659	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 7,288		
The Rotary Club Dues	\$ 300		
Total Dues	\$ 7,588	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Political Contributions - Disallowed	\$ 675		
Total Contributions	\$ 675	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Consulting Fees - Admission	\$ 9,471		
Purchased Services - Fiscal Operations	\$ 37,445		
IT Services - Administrative Staff	\$ 31,200		
Licenses and Permits - Administration	\$ 880		
Background Check - Administration and Security	\$ 7,414		
Penalties - Administration - Disallowed	\$ 20,136		
Bank Charges - Administration - Disallowed	\$ 21,688		
Crime Insurance - Administration - Disallowed	\$ 1,023		
IT Services - Fiscal Operations	\$ 32,002		
Miscellaneous Expense - Administration - Disallowed	\$ 1,798		
Prior Period Expense - Disallowed	\$ 12,144		
Amortization of Goodwill- Disallowed	\$ 88,432		
Computer License Fee - Administration	\$ 9		
Purchased Services - Administration	\$ 365		
Fees - Human Resources	\$ 21,490		
Total Other Administrative and General	\$ 285,497	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
New Milford Crossings, LLC / DBA Villa	2330	9/30/2018	17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
National Healthcare	433,572	See attached	Page 16, line m12

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

Start Date: 10/1/2017		0101	0102	0103	0104	0105	0106	0107	0108	0109	0110	0112
End Date: 9/30/2018		Bloomfield	Bristol	Cambridge	Ludlowe	Maple View	Marlborough	Milford	New Milford	Regency	Riverside	Water's Edge
						Manor						
	Beds	90	132	160	144	120	90	120	95	130	345	15
	Bed %	1.78%	2.60%	3.16%	2.84%	2.37%	1.78%	2.37%	1.87%	2.56%	6.80%	2.96%
300001-0000-00-000-0	TROY Shared Cost	(1,943.94)	(2,742.10)	(3,324.01)	(2,991.65)	(2,493.45)	(1,943.94)	(2,493.45)	(1,973.65)	(2,700.62)	(7,167.87)	(3,116.89
391500-0000-00-000-0	Misc. Other Income-Nat. Mgmt	(1.81)	(2.65)	(3.21)	(2.89)	(2.41)	(1.81)	(2.41)	(1.91)	(2.61)	(6.92)	(3.01
400000-0000-00-000-0	Salary-National Healthcare Management	264,999.02	364,469.85	441,813.25	397,631.70	331,394.61	264,999.02	331,394.61	262,318.45	358,952.32	952,686.82	414,240.5
401000-0000-04-000-0 401100-0000-04-000-0	FICA-National Healthcare Management-Fiscal Oper -	17,230.93 122.65	23,620.40 176.14	28,632.84 213.50	25,769.50 192.18	21,476.78 160.15	17,230.93 122.65	21,476.78 160.15	17,000.17 126.74	23,262.74 173.47	61,741.11 460.40	26,845.7 200.1
401200-0000-04-000-0	FUI-National Healthcare Management-Fiscal Oper SUI-National Healthcare Management-Fiscal Oper	925.43	1,370.82	1,661.73	1,495.53	1,246.47	925.43	1,246.47	986.69	1,350.09	3,583.22	1,558.0
401201-0000-00-000-0	SUI - NY-National Healthcare Management	99.64	109.61	132.86	119.58	99.64	99.64	99.64	78.87	107.94	286.49	124.5
401250-0000-00-000-0	NY MTA Tax-Nat. Mgmt	513.04	687.23	833.06	749.74	624.88	513.04	624.88	494.61	676.82	1,796.39	781.0
401300-0000-04-000-0	Health Insurance-National Healthcare-Fiscal Op	23,804.70	32,374.53	39,244.43	35,320.56	29,437.89	23,804.70	29,437.89	23,300.86	31,884.16	84,625.87	36,798.2
401400-0000-04-000-0	Workers Compensation-National Health-Fiscal Op	(77.84)	168.85	204.88	184.32	153.83	(77.84)	153.83	121.79	166.50	441.80	192.2
401600-0000-04-000-0	Disability Expense-National Healthca-Fiscal Op	(2.29)	(2.52)	(3.05)	(2.75)	(2.29)	(2.29)	(2.29)	(1.81)	(2.48)	(6.58)	(2.86
401700-0000-04-000-0	Pension-National Healthcare Manageme-Fiscal Op-	3,611.35	5,295.00	6,418.82	5,776.89	4,815.09	3,611.35	4,815.09	3,811.31	5,215.02	13,841.42	6,018.9
401800-0000-04-000-0 402000-0000-04-000-0	Employee Benefits - Other-National H-Fiscal Op	765.51	962.82	1,166.99	1,050.39	875.37	765.51	875.37	692.88	948.16	2,516.49	1,094.2
410000-0000-04-000-0	Holiday Expense-National Healthcare -Fiscal Op Supplies-National Healthcare Managem-Fiscal Op	1,470.14 1,113.16	1,623.17 1,446.66	1,967.41 1,753.81	1,770.81 1,578.28	1,475.56 1,315.29	1,470.14 1,113.16	1,475.56 1,315.29	1,167.93 1,041.26	1,598.36 1,424.67	4,242.47 3,781.51	1,844.6 1,644.2
410000-0000-04-000-0	Supplies-National Healthcare Managem-Maintenan-	0.20	0.30	0.36	0.32	0.27	0.20	0.27	0.21	0.29	0.78	0.3
410000-0000-09-000-0	Supplies-National Healthcare Managem-Housekeep	18.93	26.69	32.38	29.13	24.28	18.93	24.28	19.20	26.30	69.81	30.3
411000-0000-04-000-0	Food-National Healthcare Management-Fiscal Ope	20.06	27.04	32.78	29.51	24.59	20.06	24.59	19.45	26.63	70.67	30.7
431000-0000-04-000-0	Consulting Fees-National Healthcare -Fiscal Op	3,349.05	4,263.06	5,167.60	4,650.98	3,876.11	3,349.05	3,876.11	3,068.01	4,198.32	11,143.22	4,845.3
432000-0000-03-000-0	Accounting Fees-National Healthcare -Administr	323.10	465.10	563.72	507.39	422.91	323.10	422.91	334.74	458.02	1,215.68	528.6
433000-0000-03-000-0	Legal Fees-National Healthcare Manag-Administr-	24,519.09	33,704.09	40,856.21	36,771.08	30,647.18	24,519.09	30,647.18	24,257.98	33,193.69	88,101.52	38,309.6
433100-0000-03-000-0 433300-0000-03-000-0	Legal Fees - Labor-National Healthca-Administr Legal Fees - Non-reimbursa-National -Administr	(20.11)	(29.49)	(35.75)	(32.18)	(26.82)	(20.11)	(26.82)	(21.23)	(29.05)	(77.09) 0.00	(33.52
440000-0000-03-000-0	Purch Services-National Healthcare M-Administr	8.110.46	10.634.36	12,890,41	11.601.74	9,669,40	8.110.46	9.669.40	7.653.29	10.473.00	27,796,95	12,086,9
440000-0000-08-000-0	Purch Services-National Healthcare M-Maintenan	3,689,99	4,657.05	5.645.05	5.080.76	4.234.32	3,689.99	4,234.32	3,351.62	4,586,36	12,172.96	5,293.0
440000-0000-09-000-0	Purch Services-National Healthcare M-Housekeep	550.95	707.55	857.74	771.99	643.33	550.95	643.33	509.19	696.80	1,849.61	804.2
440000-0000-12-000-0	Purch Services-National Healthcare Ma-Security	3.49	3.83	4.65	4.18	3.49	3.49	3.49	2.76	3.78	10.03	4.3
440001-0000-08-000-0	Ground Services-Nat. MgmtMaintenance	18.23	25.09	30.45	27.37	22.84	18.23	22.84	18.05	24.71	65.63	28.5
441000-0000-03-000-0	Computer Expense-National Healthcare-Administr	9,602.89	13,073.52	15,847.76	14,263.11	11,887.53	9,602.89	11,887.53	9,409.41	12,875.56	34,173.29	14,859.7
452000-0000-25-000-0	Equipment Rental-National Healthcare-Fiscal Op-	2,319.41	3,138.88	3,804.96	3,424.55	2,854.12	2,319.41	2,854.12	2,259.02	3,091.35	8,204.98	3,567.6
461000-0000-03-000-0 461100-0000-03-000-0	Telephone-National Healthcare Manage-Administr Telephone - Cell-National Healthcare-Administr	2,817.94 1,536.11	3,819.97 2,072.18	4,630.55 2,511.95	4,167.56 2,260.77	3,473.48 1,884.24	2,817.94 1,536.11	3,473.48 1,884.24	2,749.31 1,491.39	3,762.17 2,040.77	9,985.33 5,416.67	4,341.9 2,355.3
462000-0000-25-000-0	Electric-National Healthcare Manageme-Property -	1,837.33	2,467.33	2,911.95	2,260.77	2,243.49	1,837.33	2,243.49	1,775.81	2,429.96	6,449.47	2,804.4
463000-0000-25-000-0	Gas-National Healthcare Management-Property -	305.79	428.06	518.92	467.02	389.27	305.79	389.27	308.12	421.60	1,118.98	486.5
466000-0000-25-000-0	Water-National Healthcare Management-Property-	132.24	179.75	217.90	196.11	163.47	132.24	163.47	129.35	177.04	469.89	204.3
471000-0000-25-000-0	Rent-National Healthcare Management-Property	14,794.21	19,905.81	24,129.69	21,717.14	18,100.00	14,794.21	18,100.00	14,326.56	19,604.14	52,032.82	22,625.5
472000-0000-25-000-0	Personal Property Taxes-National Hea-Fiscal Op	820.78	1,099.95	1,333.33	1,199.88	1,000.03	820.78	1,000.03	791.68	1,083.24	2,875.08	1,250.0
473000-0000-25-000-0	Real Estate Taxes-National Healthcar-Fiscal Op	(716.91)	(780.76)	(946.34)	(851.77)	(709.74)	(716.91)	(709.74)	(561.77)	(768.82)	(2,040.66)	(887.27
484000-0000-04-000-0	Amort Exp - LHI-National Healthcare -Fiscal Op -	582.08	940.32	1,139.91	1,025.95	855.15	582.08	855.15	676.88	926.15	2,458.10	1,068.9
486000-0000-04-000-0 491000-0000-03-000-0	Dep Exp - Moveable Equip-National He-Fiscal Op Dues and Subscriptions-National Heal-Administr	8,998.22 392.70	12,011.33 526.60	14,559.99 638.32	13,104.26 574.53	10,921.61 478.78	8,998.22 392.70	10,921.61 478.78	8,644.68 379.01	11,829.25 518.58	31,396.88 1,376.35	13,652.3 598.5
500000-0000-03-000-0	Licenses and Permits-National Health-Administr -	123.38	176.67	214.25	192.80	160.69	123.38	160.69	127.18	174.03	461.97	200.8
501000-0000-03-000-0	Advertising Employment-National Heal-Administr-	5,150.47	6,788.98	8,229.43	7,406.65	6,172.94	5,150.47	6,172.94	4,886.01	6,685.99	17,745.85	7,716.3
501100-0000-03-000-0	Advertising Promotional-National Hea-Administr	6,954.58	8,856.77	10,735.89	9,662.06	8,051.97	6,954.58	8,051.97	6,373.80	8,722.33	23,149.01	10,064.8
503000-0000-03-000-0	Interest-National Healthcare Managem-Administr	895.38	1,098.38	1,331.31	1,198.33	998.60	895.38	998.60	790.44	1,081.65	2,871.00	1,248.3
503600-0000-03-000-0	Bank Charges-Nat. MgmtAdministration	757.75	1,056.89	1,281.21	1,153.05	961.02	757.75	961.02	760.70	1,040.90	2,762.72	1,201.3
504000-0000-03-000-0	Postage-National Healthcare Manageme-Administr-	939.48	1,285.69	1,558.48	1,402.60	1,168.99	939.48	1,168.99	925.33	1,266.22	3,360.57	1,461.3
509000-0000-03-000-0 510000-0000-03-000-0	Seminars-National Healthcare Managem-Administr Liability Insurance-National Healthc-Administr	592.62 1,518.24	822.89 2,077.00	997.58 2,517.78	897.78 2.266.01	748.24 1,888.66	592.62 1,518.24	748.24 1,888.66	592.26 1,494.90	810.47 2,045.59	2,151.03 5,429.23	935.3 2,360.8
511000-0000-03-000-0	Auto Insurance-National Healthcare M-Administr -	996.03	1,333.80	1,616.83	1,455.12	1,212.80	996.03	1,212.80	959.97	1,313.58	3,429.23	1,516.0
512000-0000-03-000-0	Umbrella Insurance-National Healthca-Administr-	(442.70)	(430.00)	(521.18)	(469.13)	(390.86)	(442.70)	(390.86)	(309.32)	(423.38)	(1,123.82)	(488.58
513000-0000-03-000-0	Crime Insurance-National Healthcare -Administr	947.46	1,166.02	1,413.38	1,272.10	1,060.18	947.46	1,060.18	839.13	1,148.33	3,047.81	1,325.2
517000-0000-03-000-0	Wor`kmans Comp Insurance-National	278.49	306.35	371.32	334.21	278.49	278.49	278.49	220.42	301.67	800.70	348.1
520000-0000-03-000-0	Auto Expense-National Healthcare Man-Administr	530.80	907.18	1,099.76	989.67	825.02	530.80	825.02	653.07	893.56	2,371.43	1,031.2
520100-0000-03-000-0	Auto Lease Expense-National Healthca-Administr	2,720.79	3,695.41	4,479.70	4,031.69	3,360.32	2,720.79	3,360.32	2,659.89	3,639.77	9,659.84	4,200.4
521000-0000-03-000-0	Travel Expense-National Healthcare M-Administr-	5,832.23	7,907.91	9,585.93	8,627.39	7,190.06	5,832.23	7,190.06	5,691.44	7,788.04	20,670.14	8,987.5
522000-0000-03-000-0 541000-0000-03-000-0	Hotel Expense-National Healthcare Ma-Administr Misc. Expense-Nat. MgmtAdministration	4,712.59 777.96	6,429.75 1,039.12	7,794.21 1,259.58	7,014.86 1,133.63	5,846.35 944.89	4,712.59 777.96	5,846.35 944.89	4,627.67 747.81	6,332.36 1,023.30	16,806.94 2,716.08	7,307.9 1,181.0
541000-0000-03-000-0 541000-0000-31-000-0	Misc. Expense-Nat. MgmtAdministration Misc. Expense-National Healthcare Ma-Misc. Exp	1,780.05	2,037.60	1,259.58 2,469.82	1,133.63 2,223.01	1,852.43	1,780.05	1,852.43	1,466.23	2,006.59	2,/16.08 5,325.83	1,181.0 2,315.6
541001-0000-31-000-0	Political Contributions-Nat. MgmtAdministrat-	1,780.05	130.85	158.60	142.75	1,652.45	1,760.05	1,052.45	94.15	128.85	342.00	2,315.0
542000-0000-31-000-0	Corporate Tax - State-National Healt-Misc. Exp	609.38	928.50	1,125.59	1,013.04	844.18	609.38	844.18	668.29	914.48	2,426.93	1,055.1
544000-0000-25-000-0	Sales Tax - ConnNational Healthcar-Fiscal Op		5,023.32	6,089.14	5,480.29				3,615.61	4,947.70	13,129.66	5,708.4
310000-0000-00-000-0	Prior period shared costs	(1,333.06)	3,216.77	1,187.26	(2,621.81)	-1333.06	-3916.66	-3745.07	2,314.18	(2,118.67)		(400.50
310000-0000-00-000-0	Prior period shared consulting	5,907.08	2,927.70	7,876.09	9,326.34	5907.08	8490.68	7772.04	2,460.43	8,651.34		7,383.7
Variance		196.34	215.98	261.79	235.63	196.34	196.34	196.34	155.41	212.68	564.51	245.4

TOTAL EXPENSES

	437,200.21	601,924.95	731,270.49	656,693.44	541,725.02	437,200.21	541,177.97	433,571.91	593,291.76	1,557,315.44	684,131.78
Page 16 M12	437,200	601,926	731,271.00	656,694	541,725	437,199	541,178	433,572	593,291.00	1,557,315	684,132
Variance	0	(1)	(1)	(1)	0	1	(0)	(0)	1	0	(0)

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

Note on Page 5)											
			No.	Report for Y		Page of					
New	Milford Crossings, LLC / DBA Village Crest C	en	2330	9/30/2018		18 37					
	Item		Total	CCNH	RHNS	(Specify)					
2.	Dietary										
	a. In-House Preparation & Service										
	1. Raw Food	\$	199,263	199,263							
	2. Non-Food Supplies	\$	27,934	27,934							
	3. Other (<i>Specify</i>)	\$									
	b. Purchased Services (by contract other	\$									
	than through Management Services)										
	(Complete Schedule C-2 att. Page 21)										
	c. Other (Specify)	\$									
		=									
2D.	Total Dietary Expenditures $(2a + b + c + d)$	\$	227,197	227,197							
2E	Dietary Questionnaire		Total	CCNH	RHNS	(Specify)					
		Ψ	Total	CCNII	KIINS	(Specify)					
G.	Resident Meals: Total no. of meals served per d	•									
H.	Is cost of employee meals included in 2E?) Yes	•	No							
I.	Did you receive revenue from employees?) Yes	0	No	If yes, specify						
1.	Did you receive revenue from employees?) ies	•	NO	amt.						
J.	Where is the revenue received reported in the Co	ost Report	t? (Page/Line	Item)							
	Is cost of meals provided to persons other			-	10 '0						
K.	<u> </u>) Yes	•	No	If yes, specify						
	Members, Guests) included in 2E?				cost.						
					If yes, specify						
L.	Is any revenue collected from these people?) Yes	⊙	No	amt.						
N	Where is the revenue received remarked in the C	ogt Danas	2 (Daga/Lin -	Itam)	willt.						
IVI.	Where is the revenue received reported in the Co	osi Kepori	rage/Line	110111)							
	Is cost of food (other than meals, e.g.,				10 10						
N.	snacks at monthly staff meetings, board) Yes	•	No	If yes, specify						
	meetings) provided to employees included				cost.						
	in 2E?										
O.	Is any revenue collected from employees?) Yes	•	No	If yes, specify						
	is any revenue conceind from employees.			110	amt.						
P.	Where is the revenue received reported in the Co	ost Report	? (Page/Line	Item)							
	1		· ·								

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

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

Name of Facility New Milford Crossings, LLC / DBA Village Crest Center			No.	Report for Y		Page	of
New	Milford Crossings, LLC / DBA Village Crest Cente	1	2330	9/30/2018	1	19	37
	Item		Total	CCNH	RHNS	(Spe	cify)
3.	Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies,	Lbs.					
	gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	10,722	10,722			
	2. Employee items including uniforms, gowns, etc. washed, ironed and/or	Lbs.					
	processed.***	Amt. \$					
	3. Personal clothing of residents	Lbs.					
	washed, ironed, and/or processed.***	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)	\$					
	c. Other (Specify)	\$	40,873	40,873			
	Diapers \$31,790; Supplies \$9,083						
3D.	Total Laundry Expenditures $(3a+b+c)$	\$	51,595	51,595			
3F. G.	Laundry Questionnaire Is cost of employee laundry included in 3E? O	Yes	•	No	If yes, specify cost.		
Н.	Did you receive revenue from employees?	Yes	•	No	If yes, specify amt.		
I.	Where is the revenue received reported in the Cost R	Report?		(Page/Line	(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 R	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.

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		Repo	ort for Year E	nded	Page	of
New Milford Crossings, LLC / DBA Village Cr	2330	<u> </u>	9/30/2018		20	37
Item	T		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced					
a. In-House Care	by Personnel					
1. Supplies - Cleaning (<i>Mops</i> ,	Amt.	\$	26,898	26,898		
pails, brooms, etc.)						
b. Purchased Services (by contract other	Sq. Ft. Serviced					
than through Management Services)	by Personnel					
(Complete Schedule C-2 att.	Amt.	\$				
Page 21)						
C. Other (<i>Specify</i>)		\$				
	4D. Total Housekeeping Expenditures (4a + b + c)					
5. Resident Care (Supplies)**		- 1				
a. Prescription Drugs***						
1. Own Pharmacy		\$				
2. Purchased from		\$	144,585	144,585		
		- 1				
b. Medicine Cabinet Drugs		\$	9,012	9,012		
c. Medical and Therapeutic Supplies		\$	81,525	81,525		
d. Ambulance/Limousine***		\$	3,513	3,513		
e. Oxygen						
1. For Emergency Use		\$				
2. Other***		\$	4,690	4,690		
f. X-rays and Related Radiological		\$	7,646	7,646		
Procedures***						
g. Dental (Not dentists who should be inc	luded under	\$				
salaries or fees)						
h. Laboratory***		\$	14,675	14,675		
i. Recreation		\$	14,555	14,555		
j. Direct Management Services*		\$	·	,		
k. Indirect Management Services*		\$				
l. Other (Specify)****		\$	36,168	36,168		
See Attached Schedule						
5M. Total Resident Care Expenditures (5a - 5		\$	316,369	316,369		

^{*} 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	5	(Spec	cify)
Purchased Services - Nursing	\$	568				
Equipment Rental - Nursing	\$	7,821				
Equipment Rental - Rehabilitation Therapy and Ancillary	\$	12,278				
IV Therapy Supplies	\$	3,458				
Flu Vaccine	\$	270				
Purchased Services - Rehabilitation Therapy and Ancillary	\$	25				
Equipment Rental - Respiratory	\$	11,748				
Total Other Resident Care	\$	36,168	\$	-	\$	-

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

Name of Facility		License No.		Report for Year Ended				of		
New Milford Crossings, LLC	/ DBA Village Crest	Center for He	ealth and Re	2330	9/30/2018				21	37
		Related ** to Owners, Operators, Officers					/Page Ref.**	*		
Name of Individual or Company	Address	Yes	No	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	(Specify)	Ρσ	Line
ADM Environmental Group	Avenue, Brooklyn, NY 11230	0	•	101000	Trash Removal	19,922	Tun (a	(specify)		6f
ADP	P.O. Box 842875, Boston, MA 02284 Overland Parks, KS	0	•		PR Processing	11,372			16	m13
Integrated Health Systems	66283	0	•		Computer Maintenance	10,660			16	m13
Mike and Karen's Lawn Unlimited, LLC	186 Cornwall Road, Warren, CT 06754	0	•		Landscaping	15,101			22	6f
		0	•							
		0	•							
		0	•							
		0	•							
		0	•							
		0	•							
		0	•							
		0	•							
		0	•							
		0	•							

^{*} List all contracted services over \$10,000. Use additional sheets if necessary.

^{**} Refer to Page 4 for definition of related.

^{***} Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility License No.		Report for Ye	ear Ended		Page	of
New Milford Crossings, LLC / DBA Village C 2330		9/30/2018			22	37
Item		Total	CCNH	RHNS	(Sp.	ecify)
6. Maintenance & Operation of Plant		10111	CCIVII	Turio	(Sp	cerry)
a. Repairs & Maintenance	\$	93,502	93,502			
b. Heat	\$	16,588	16,588			
c. Light & Power	\$	182,914	182,914			
d. Water	\$	50,234	50,234			
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$	34,256	34,256			
f. Other (itemize)	\$	38,852	38,852			
See Attached Schedule	4	33,322	20,002			
6g. Total Maint. & Operating Expense (6a - 6f)	\$	416,346	416,346			
7. Depreciation (complete schedule page 23*)			·			
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$	46,001	46,001			
*7e. <i>Total Depreciation Costs</i> (7a + b + c + d)	\$	46,001	46,001			
8. Amortization (Complete att. Schedule Page 24*)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$	125,313	125,313			
d. Other (<i>Specify</i>)	\$					
*8e. <i>Total Amortization Costs</i> (8a + b + c + d)	\$	125,313	125,313			
9. Rental payments on leased real property less						
real estate taxes included in item 10b	\$	372,000	372,000			
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	78,606	78,606			
c. Personal property taxes	\$	5,389	5,389			
11. <i>Total Property Expenses</i> (7e + 8e + 9 + 10)	\$	627,309	627,309			

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

Schedule of Other Repairs and Maintenance

Description	(CCNH	RHNS	(Specify)
Ground Services - Maintenance	\$	15,101		
Pest Control - Maintenance	\$	1,728		
Carting - Maintenance	\$	17,696		
Equipment Rental - Maintenance	\$	2,552		
Equipment Rental - Dietary	\$	1,775		
Total Other Repairs and Maintenance	\$	38,852	\$ -	\$ -

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

Depreciation Schedule

Name of Facility					License No.	iation Sc		Report for Year E	nded		Page	of
New Milford Crossings, LLC / DBA Village	Crest (Center	for Hea	alth and	233	0		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					Build	,	Бергеелией	орышлень	2 oproduction		101 11110 1 0411	10000
Acquired prior to this report period												
Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal												
B. Building and Building Improvements												
Acquired prior to this report period												
Disposals (attach schedule)												
3. Acquired during this report period (attac	h sched	lule)										
B-4. Subtotal												
C. Non-Movable Equipment												
Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attac	h sched	lule)										
C-4. Subtotal												
	Is a m	ileage										
		ook						Accumulated				
			Date of A	cquisition	Historical Cost	Less		Depreciation to	Method of			
					Exclusive of	Salvage	Cost to Be	Beginning of	Computing	Useful	Depreciation	
	Yes	No	Month	Year	Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
D. Movable Equipment							1	1	1			
Motor Vehicles (Specify name, model												
and year of each vehicle)												
a. Honda Odyssey		X	April	2014	15,661		15,661	13,703	SL	4	1,958	
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					305,626		305,626	105,234	SL	Various	42,605	
b. Disposals (attach schedule)												
c. Acquired during this report period												
(attach schedule)					20,792		20,792		SL	Various	1,438	
D-3. Subtotal												46,001
E. Total Depreciation												46,001

New Milford Crossings, LLC / DBA Village Crest Center for Health and Rehabilitation 9/30/2018

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:	F			
Total additions for Land Impro	ovements	\$ -		\$ -
Deletions:				
Total deletions for Land Impro	vements	\$ -		\$ -

^{*}Ties to Page 23, Line A3

Schedule of Building Improvements Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
Total additions for	Building Improvements	\$ -		\$ -
Deletions:				
Total deletions for l	Building Improvements	\$ -		\$ -
	U .			

^{*}Ties to Page 23, Line B3

Schedule of Non-Movable Equipment Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:	-			
Total additions for No	on-Movable Equipment	\$ -		\$ -
Deletions:				
Total deletions for No	on-Movable Equipment	\$ -		\$ -

^{*}Ties to Page 23, Line C3 **Ties to Page 23, Line C2

^{**}Ties to Page 23, Line A2

^{**}Ties to Page 23, Line B2

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation		
Additions:	•					
11/30/2017	Nobles Speedshine Burnisher	\$ 1,177	5	\$	216	
11/30/2017	Mattress- Pressure Relief System	\$ 691	5	\$	127	
10/1/2017	Tax on asset #242	\$ 43	5	\$	9	
12/31/2017	Computers with monitors SmartBuy	\$ 2,622	3	\$	728	
7/31/2018	Washer parts replacement	\$ 7,384	15	\$	123	
8/31/2018	Ultrasound bladder scanner	\$ 8,136	7	\$	194	
8/31/2018	Desktop computer	\$ 739	3	\$	41	
Total additions for N	Movable Equipment	\$ 20,792		\$	1,438	
Deletions:						
Total deletions for M	Joyable Equipment	\$ _		\$		

^{*}Ties to Page 23, Line D2c **Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

				Useful		
Acquisition Date	Description of Item		Cost	Life	Dep	reciation
Additions:						
10/31/2017		\$	3,765	5	\$	753
11/30/2017	S	\$	3,795	5	\$	696
10/31/2017	5	\$	4,613	5	\$	923
12/31/2017	<u> </u>	\$	3,765	5	\$	63
	GE Zoneline PTAC Heat Pump	\$	1,351	10	\$	101
1/31/2018	S	\$	1,575	5	\$	236
2/28/2018	Painting	\$	2,542	5	\$	339
2/28/2018	Generator stairs and landing	\$	2,900	20	\$	97
3/31/2018	Painting	\$	2,325	5	\$	271
3/31/2018	cubicle curtains	\$	1,993	5	\$	232
3/31/2018	Cubicle curtains	\$	4,066	5	\$	474
4/30/2018	Painting	\$	2,175	5	\$	218
5/31/2018	Painting	\$	4,065	5	\$	339
5/31/2018	PTAC Heat Pump system	\$	1,502	10	\$	63
6/30/2018	Painting	\$	4,723	5	\$	315
1/1/2018	Vinyl cove base	\$	326	10	\$	24
1/1/2018	Vinyl flooring	\$	3,908	10	\$	293
1/1/2018	Design for wall finishes	\$	957	5	\$	144
1/1/2018	Wall covering	\$	10,702	5	\$	1,605
7/31/2018	Painting	\$	3,238	5	\$	162
1/31/2018	Painting	\$	2,195	10	\$	165
8/31/2018	Painting	\$	4,260	5	\$	142
9/30/2018	Painting	\$	3,337	5	\$	56
1/1/2018	Painting	\$	3,060	5	\$	459
	easehold Improvement	\$	77,138		\$	8,170
Deletions:						
1/1/2018	Painting	\$	(3,765)	5	\$	(63)
Total deletions for L	easehold Improvement	\$	(3,765)		\$	(63)
Total describing for E	casenora improvement	Ψ	(3,703)		4	(05)

^{*}Ties to Page 24, Line C3
**Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility

CSP-24 Rev. 10/2006

Amortization Schedule*

Nam	e of Facility			License No.		Report for Yea	r Ended		Page	of
New	Milford Crossings, LLC / DBA Village C	Crest Cer	nter for	233	30	9/30/2018			24	37
						Accumulated				
		Date	e of			Amort. to				
		Acqui	sition			Beginning of	Basis for			
				Length of	Cost to Be	Year's	Computing	Rate	Amortization	
	Item	Month	Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
A.	Organization Expense									
	1.									
	2.									
	3.									
A-4.	Subtotal									
B.	Mortgage Expense									
	1.									
	2.									
	3.									
B-4.	Subtotal									
C.	Leasehold Improvements and Other									
	1. Acquired prior to this report period				1,182,532	184,319	SL		117,206	
	2. Disposals (attach schedule)				(3,765)		SL		(63)	
	3. Acquired during this report period									
	(attach schedule)				77,138		SL		8,170	
C-4.	Subtotal									125,313
D.	Total Amortization									125,313

^{*} Straight-line method must be 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.

^{**} Specify which of the following bases were used:

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

Name of Facility New Milford Crossings, LLC	License No.		Report for Year End 9/30/2018	ded		Page 25	of 37
11. Property Questionnaire						<u> </u>	
Part A Is the property either own or leased from a Related I *If any owner or operator business association to any related party transaction.	Party?* of this facility is related b	y family, mai		to control or	No	If "Yes," complete I If "No," complete Pa	
	ription		Total				
Date Land Purchased	•		08/01/68				
2. Date Structure Comp			06/01/71				
3. If NOT Original Own	02/01/08						
4. Date of Initial Licens	06/01/71						
5. Total Licensed Bed C	apacity		95				
6. Square Footage7. Acquisition Cost			44,020				
a. Land			59,000				
b. Building			533,000				
Part B - Owner and Rel	ated Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage	e
1. Financing			0 0			9 0	
a. Type of Financing		e)	Fixed				
b. Date Mortgage O			07/01/16				
c. Interest Rate for the			4.85%				
d. Term of Mortgage			5				
e. Amount of Princip	outstanding as of 9/3	20/10	1,325,000				
Complete if Mortga		00/10	1,014,556				
During Current	~						
g. Type of Financing		<u>e)</u>					
h. Date of Refinanci		-)					
i. New Interest Rate							
j. Term of Mortgage	e (number of years)						
k. Amount of Princip							
	ding on Note Paid-O						
Part C - Arms-Leng					ı	ı	
Name and Address	of Lessor	Pro	perty 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.

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

Name of Facility License No.		Report for Ye	ar Ended		Page of
New Milford Crossings, LLC / DBA \ 2330		9/30/2018			26 37
Item		Total	CCNH	RHNS	(Specify)
12. Interest		10001	001111	Tarris	(Specify)
A. Building, Land Improvement & Non-Movable					
Equipment					
First Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
2. Second Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
3. Third Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
B. CHEFA Loan Information					
1. Original Loan Amount	\$				
2. Loan Origination Date					
3. Interest Rate %					
4. Term					
5. CHEFA Interest Expense					
12 B7. Total Building Interest Expense (A1 - A4 + B5)	\$				

(Carry Subtotals forward to next page)

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

Name of Facility License N	No.		Report for Ye	ear Ended		Page of		
<u> </u>	330		9/30/2018			27	37	
Item			Total	CCNH	RHNS	(Spec	ify)	
Sub	totals Brou	ıght Forward:					•	
12. C. Movable Equipment								
1. Automotive Equipment		\$						
A. Item	Rate	Amount						
Lender	<u> </u>							
Address of Lender								
2. Other (<i>Specify</i>)		\$	40,905	40,905				
A. Item	Rate	Amount	10,505	.0,703				
Equipment Loan - Various	4.75%	40,905						
Lender	1	-,, -						
Webster Bank								
Address of Lender								
P.O. Box 191Waterbury, CT 06720-0191								
B. Item	Rate	Amount						
Lender								
Address of Lender								
12. C. 3. Total Movable Equipment Interes	est							
Expense $(C1 + 2)$		\$	40,905	40,905				
12. D. Other Interest Expense (Specify)		\$	4,853	4,853				
Administration \$2,206; Computer I	Loan \$2,64	7						
13. Total All Interest Expense (12B7 + 120	C3 + 12D)	\$	45,758	45,758				
14. Insurance								
a. Insurance on Property (buildings on	ly)	\$	14,228	14,228				
b. Insurance on Automobiles		\$	3,177	3,177			-	
c. Insurance other than Property (as sp	ecified abo	ve)						
1. Umbrella (Blanket Coverage)		\$		9,880				
2. Fire and Extended Coverage		\$						
3. Other (<i>Specify</i>)		\$	38,683	38,683				
Liability Insurance								
14d. Total Insurance Expenditures (14a + 1		\$		65,968				
15. Total All Expenditures (A-13 thru C-1	4)	\$	8,691,823	8,691,823				

D. Adjustments to Statement of Expenditures

	e of Fa	-	ossings, LLC / DBA Village Crest Center for H		eense No.	Report for Yea 9/30/2018	r Ended	Page 28	of 37
INCW	IVIIIIO	lu Cit	Issings, LLC / DBA vinage crest center for 1		Total	7/30/2016		20	31
T.	ъ	_T .							
	Page				Amount of	COM	DIDIG	(0	
	No.		Item Description		Decrease	CCNH	RHNS	(Spe	cify)
	10 - 5	Salari	es and Wages						
1.			Outpatient Service Costs	\$					
2.	10	12m	Salaries not related to Resident Care	\$	11,636	11,636			
3.			Occupational Therapy	\$					
4.			Other - See attached Schedule	\$					
_	13 - I	Profes	sional Fees						
5.			Resident Care Physicians **	\$					
6.	13	10a	Occupational Therapy	\$	222,714	222,714			
7.			Other - See attached Schedule	\$	42,711	42,711			
Page.	s 15 &	2 16 -	Administrative and General						
8.			Discriminatory Benefits	\$					
9.			Bad Debts	\$					
10.			Accounting	\$					
10a.			Legal	\$	9,541	9,541			
11.			Telephone	\$					
12.	15	1h2	Cellular Telephone	\$	1,048	1,048			
13.			Life insurance premiums on the life						
			of Owners, Partners, Operators	\$					
14.			Gifts, flowers and coffee shops	\$					
15.			Education expenditures to colleges or						
			universities for tuition and related costs						
			for owners and employees	\$					
16.			Travel for purposes of attending						
			conferences or seminars outside the						
			continental U.S. Other out-of-state						
			travel in excess of one representative	\$					
17.			Automobile Expense (e.g. personal use)	\$					
18.	16	m3	Unallowable Advertising *	\$	19,659	19,659			
19.	15	1J	Income Tax / Corporate Business Tax	\$	1,115	1,115			
20.	16		Fund Raising / Contributions	\$	675	675			
21.	15	1d	Unallowable Management Fees	\$	246,222	246,222			
22.			Barber and Beauty	\$	· • ,—- 	,			
23.			Other - See attached Schedule	\$	213,458	213,458			
	18 - 1	Dietar	y Expenditures	Ψ	213,130	213,133			
24.	10 1		Meals to employees, guests and others						
			who are not residents	\$					
Ρασρ	19 - 1	โสมทศ	lry Expenditures	Ψ					
25.	1,-1		Laundry services to employees, guests	\dashv					
۷۶.			and others who are not residents	\$					
Page	20 = 1	House	ekeeping Expenditures	ψ					
26.	20 - I	iouse	Housekeeping services to employees, guests						
∠0.				¢					
			and others who are not residents	\$	7(0.770	769.770			
			Subtotal (Items 1 - 26)	\$	768,779	768,779			

^{*} All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Othe	r Salaries A	djustment	\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	(CCNH	RHNS	(Specify)
13	B2	Dentist	\$	6,531		
13	B2	Pharmacist	\$	10,744		
13	8a	Medical Director (over the limit)	\$	15,977		
13	B12	Consulting Fees - Rehabilitation Therapy & Ancillary	\$	6,580		
13	B12	Consulting Fees - Nursing	\$	2,879		
				•		
Total Othe	Total Other Fees Adjustments		\$	42,711	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	C	CNH	RHNS	(Specify)
15	1a1	Benefits on Salaries not Related to Resident Care	\$	3,286		
15	1a1	Workmen's Compensation Retro	\$	62,426		
16	L3	Gifts to Residents and Staff	\$	2,245		
16	m13	Crime Insurance - Administration	\$	1,023		
16	m13	Miscellaneous Expenses	\$	1,798		
16	m13	Penalties - Administration	\$	20,136		
16	m13	Bank Charges - Administration	\$	21,688		
16	m8a	Chamber of Commerce Dues	\$	280		
16	m13	Amortization of Goodwill	\$	88,432		
16	m13	Prior Period Expense	\$	12,144		
Total Othe	r A&G Adj	ustments	\$	213,458	\$ -	\$ -

Annual Report of Long-Term Care Facility

CSP-29 Rev. 10/2006

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

Name	e of Fa	acility	D. Adjustments to Statement	cense No.	Report for Y		Page of
		-	ossings, LLC / DBA Village Crest Center for	2330	9/30/2018	211.000	29 37
				Total			
Item	Page	Line		Amount of			
	No.		Item Description	Decrease	CCNH RHNS		(Specify)
1101	1101	110.	Subtotals Brought Forward \$	768,779	768,779	Tunto	(Speeily)
Page	20 - I	Reside	nt Care Supplies***	700,779	700,773		
27.			Prescription Drugs \$	144,585	144,585		
28.	20		Ambulance/Limousine \$	3,513	3,513		
29.		5f	X-rays, etc \$	7,646	7,646		
30.		5h	Laboratory \$	14,675	14,675		
31.		5c	Medical Supplies \$	7,963	7,963		
32.			Oxygen (non emergency) \$	4,690	4,690		
33.			Occupational Therapy \$	Ź			
34.			Other - See Attached Schedule \$	44,519	44,519		
Page	22 - N	Mainte	enance 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 \$	2,293	2,293		
Page	27 - I	nsura	nce				
40.			Mortgage Insurance \$				
41.			Property Insurance \$				
Othe	r - Mis	scella					
42.			Other - Indirect \$				
43.			Interest Income on Account Rec. \$				
44.			Other - Miscellaneous Administrative \$				
45.			Management Fees Direct \$				
46.			Management Fees Indirect \$				
47.			Other - Direct \$	3,141	3,141		
	For Pr	ofit P	roviders Only				
48.			Building/Non Movable Eq. Depreciation				
			Unallowable Building Interest -				
			See Attached Schedule \$				
49.	Total	Amoi	unt of Decrease (Items 1 - 48) \$	1,001,804	1,001,804		

^{***} 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.

New Milford Crossings, LLC / DBA Village Crest Center for Health and Rehabilitation 9/30/2018

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	51	Equipment Rental	\$ 7,821		
20	51	Equipment Rental - Rehabilitation Therapy & Ancillary	\$ 12,278		
20	5a2/b/c	Procare LTC Pharmacy of CT (Disallowance of markups)	\$ 147		
20	51	IV Therapy - Rehabilitation Therapy & Ancillary	\$ 3,458		
20	51	Flu Vaccine - Medical Services	\$ 270		
20	5i	Cable TV Expense - Resident Rooms	\$ 8,772		
20	51	Equipment Rental - Respiratory	\$ 11,748		
20	51	Purchased Services - Rehabilitation Therapy & Ancillary	\$ 25		
Total Other	r Ancillary	Costs	\$ 44,519	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Exces	s Movable	Equipment Depreciation	\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH		CCNH RHNS	
22	2d	Depreciation on Mattresses & TV's	\$	2,293		
Total Othe	r Property	Adjustments	\$	2,293	\$ -	\$ -

Page Ref	Line Ref	Description	(CCNH	RHNS	(Specify)
30	IV8	Miscellaneous Other Income	\$	801		
30	IV5	Interest Income	\$	134		
27	12D	Other Interest	\$	2,206		
				·		
Total Othe	r Adjustme	nts	\$	3,141	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unall	owable Bui	lding Interest	\$ -	\$ -	\$ -

Annual Report of Long-Term Care Facility

CSP-30 Rev.10/2005

F. Statement of Revenue

- I		Report for Year Ended 9/30/2018			Page of 30 37
5/					
Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (CT only)	\$	8,435,413	8,435,413		
b. Medicaid Room and Board Contractual Allowance **	\$	(3,403,545)	(3,403,545)		
2. a. Medicaid (All other states)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (all inclusive)	\$	1,538,770	1,538,770		
b. Medicare Room and Board Contractual Allowance **	\$	511,878	511,878		
4. a. Private-Pay Residents and Other	\$	1,153,529	1,153,529		
b. Private-Pay Room and Board Contractual Allowance **	\$	(171,140)	(171,140)		
II. Other Resident Revenue			<u> </u>		
a. Prescription Drugs - Medicare	\$	104,337	104,337		
b. Prescription Drugs - Medicare Contractual Allowance **	\$	(102,704)	(102,704)		
c. Prescription Drugs - Non-Medicare	\$	33,175	33,175		†
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$	(33,021)	(33,021)		
a. Medical Supplies - Medicare	\$	(33,021)	(33,021)		
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare					+
**	\$				+
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$	40.4.61.1	40.4.61.1		
3. a. Physical Therapy - Medicare	\$	494,611	494,611		
b. Physical Therapy - Medicare Contractual Allowance **	\$	(369,150)	(369,150)		
c. Physical Therapy - Non-Medicare	\$	50,958	50,958		
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$	(47,457)	(47,457)		
4. a. Speech Therapy - Medicare	\$	81,475	81,475		
b. Speech Therapy - Medicare Contractual Allowance **	\$	(54,487)	(54,487)		
c. Speech Therapy - Non-Medicare	\$	14,164	14,164		
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$	(11,404)	(11,404)		
5. a. Occupational Therapy - Medicare	\$	408,778	408,778		
b. Occupational Therapy - Medicare Contractual Allowance **	\$	(340,195)	(340,195)		
c. Occupational Therapy - Non-Medicare	\$	49,714	49,714		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$	(44,383)	(44,383)		
6. a. Other (Specify) - Medicare	\$	7,819	7,819		
b. Other (Specify) - Non-Medicare	\$	1	1		
III. Total Resident Revenue (Section I. thru Section II.)	\$	8,307,136	8,307,136		
IV. Other Revenue*					
Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
Rental of Television and Cable Services	\$				
5. Interest Income (Specify)	\$	134	134		
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$	24,345	24,345		
V. Total Other Revenue (1 thru 8)	\$	24,479	24,479		
VI. Total All Revenue (III +V)	\$	8,331,615	8,331,615		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30, II6a	Medicare Part A Contractual Other	\$ (18,089)		
30, II6a	Medicare Part A IV Therapy	\$ 3,336		
30, II6a	Medicare Part A Laboratory	\$ 8,894		
30, II6a	Medicare Part A X-Ray	\$ 5,859		
30, II6a	Medicare Part A Settlement	\$ 8,781		
30, II6a	Medicare Part B Flu / Pneumonia	\$ 978		
30, II6a	Medicare Part B Prior Period	\$ (1,940)		
30, II6a	Medicare Contractual Other	\$ (6,014)		
30, II6a	Medicare Laboratory	\$ 2,479		
30, II6a	Medicare IV Therapy	\$ 2,073		
30, II6a	Medicare X-Ray	\$ 1,462		
Total Other	er Resident Revenue - Medicare	\$ 7,819	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	(CCNH	RHNS	(Specify)
30, II6b	Commercial Insurance Contractual Other	\$	(1,760)		
30, II6b	Commercial Insurance Laboratory	\$	909		
30, II6b	Commercial Insurance X-Ray	\$	852		
Total Othe	Total Other Resident Revenue			\$ -	\$ -

Interest Income

Account

Page Ref Acco	unt	Balance	CCNH	RHNS	(Specify)
30, Line IV Intere	est from M&T Savings Account		\$ 134		
Total Interest In	come		\$ 134	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30, IV8	United Healthcare	\$ 18,334		
30, IV8	Miscellaneous Other Income	\$ 801		
30, IV8	Provision for Income Taxes	\$ 5,210		
Total Otho	r Revenue	\$ 24,345	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Crossings, LLC / DBA	Vil 2330	9/30/2018	31	37
	Account		A	mount
Assets				
A. Current Assets				
1. Cash (on hand and in banks	s)		\$	138,468
2. Resident Accounts Receival	ble (Less Allowance	for Bad Debts)	\$	1,337,429
3. Other Accounts Receivable	(Excluding Owners	or Related Parties)	\$	
4 Inventories			\$	36,887
5. Prepaid Expenses			\$	110,482
a. Taxes		21,385		
b. Workers Compensation		27,987		
c. Management Assets		27,401		
d. See Schedule		33,709		
6. Interest Receivable			\$	
7. Medicare Final Settlement F			\$	
8. Other Current Assets (<i>itemi</i>	(ze)		\$	25,391
Patient Funds		25,391	_	
-			-	
See Schedule				
A-9. Total Current Assets (Lines A	1 thru 8)		\$	1,648,657
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost		\$	
	Accum. Deprecia	tion Net		
3. Buildings	*Historical Cost		\$	
	Accum. Deprecia			
4. Leasehold Improvements	*Historical Cost	1,255,905	\$	946,273
	Accum. Deprecia	tion 309,632 Net		
5. Non-Movable Equipment	*Historical Cost		\$	
	Accum. Deprecia			
6. Movable Equipment	*Historical Cost	326,418	\$	177,141
	Accum. Deprecia	*		
7. Motor Vehicles	*Historical Cost	15,661	\$	
	Accum. Deprecia	tion 15,661 Net		
8. Minor Equipment-Not Depr	reciable		\$	
9. Other Fixed Assets (<i>itemize</i>	·)		\$	38,370
Construction in Progress	,	38,370		2 0,2 . 0
See Schedule		-)- · ·		
B-10. <i>Total Fixed Assets</i> (Lines I	B1 thru 9)		\$	1,161,784

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

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended		Page	of
New M	Milford Crossings, LLC / DBA Vil	2330	9/30/2018		32	37
		Account			Amour	nt
			Total Brought Forward:	\$	2	,810,441
C. L	easehold or like property recorde	d for Equity Purposes.				
1.	. Land			\$		
2	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	6. Motor Vehicles	*Historical Cost				
		Accum. Depreciation	Net	\$		
	. Minor Equipment-Not Depreci			\$		
L	Total Leasehold or Like Propertic	es (C1 thru 7)		\$		
D. In	nvestment and Other Assets					
1	. Deferred Deposits			\$		
	2. Escrow Deposits			\$		
3	6. Organization Expense	*Historical Cost				
		Accum. Depreciation	Net	\$		
-	. Goodwill (Purchased Only)			\$		707,453
5	5. Investments Related to Resider	nt Care (<i>itemize</i>)		\$		
		• (:				
6	b. Loans to Owners or Related Pa			\$		
	Name and Address	Amount	Loan Date			
7	7. Other Assets (<i>itemize</i>)			\$		
/	. Other Assets (ttemtze)			Ф		_
	-					
	See Schedule					
D-8 7	Total Investments and Other Ass	ets (Lines D1 thru 7)		\$		707,453
	Total All Assets (Lines A9 + B10	` ,		\$	3	5,517,894
<u> </u>	D-9. Total All Assets (Lines A) + B10 + C0 + B0)					,011,077

^{*} 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

		Description		
	A5d	General Insurance	\$	7,39
31	A5d	Other	\$	26,31
Total Prep	aid Expens	es	\$	33,70
Schedule o		rrent Assets (itemized) Page 31 Line A8 Description		
Ĭ				
Catal Otha	u Cuuuont	Assets (Itemize)	s	
otai Otne	r Current .	Assets (Itemize)	3	
Schedule o	f Other Fiv	ted Assets (Itemize) Page 31 Line B9		
Page Ref	Line Ref	Description		
Fotal Othe	r Fixed As	ssets (Itemize)	\$	-
Schedule o	f Other As	sets Page 32 Line D7		
Page Ref	Line Ref	Description		
T 4 1 0 4				
i otai Otne	r Assets		\$	-
I otal Othe	r Assets		\$	-
I otal Otne	r Assets		S	-
Schedule o	f Notes Pay	yable (Itemize) Page 33 Line A2	S	
Schedule o	f Notes Pay	yable (Itemize) Page 33 Line A2 Description	S	
Schedule o	f Notes Pay		S	-
Schedule o	f Notes Pay		S	-
Schedule o	f Notes Pay		S	-
Schedule o	f Notes Pay		S	-
Schedule o	f Notes Pay		S	-
Schedule o	f Notes Pay		S	
Schedule o	f Notes Pay		S	-
Schedule o	f Notes Pay			-
Schedule o	f Notes Pay			-
Schedule o Page Ref	f Notes Pay			
Schedule o	f Notes Pay Line Ref	Description Trent Liabilities (Itemize) Page 33 Line A12		-
Schedule o	f Notes Pay Line Ref	Description		-
Schedule o	f Notes Pay Line Ref	Description Trent Liabilities (Itemize) Page 33 Line A12		-
Schedule o	f Notes Pay Line Ref	Description Trent Liabilities (Itemize) Page 33 Line A12		-
Schedule o	f Notes Pay Line Ref	Description Trent Liabilities (Itemize) Page 33 Line A12		-
Schedule o	f Notes Pay Line Ref	Description Trent Liabilities (Itemize) Page 33 Line A12		-
Schedule o Page Ref Fotal Notes Schedule o	f Notes Pay Line Ref	Description Trent Liabilities (Itemize) Page 33 Line A12 Description	S	-
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Fotal Notes Schedule o Page Ref Fotal Notes	f Notes Pay Line Ref s Payable f Other Cu Line Ref	Description Trent Liabilities (Itemize) Page 33 Line A12 Description Liabilities (Itemize)	S	-
Fotal Notes Schedule o Page Ref Fotal Notes	f Notes Pay Line Ref s Payable f Other Cu Line Ref	Description Trent Liabilities (Itemize) Page 33 Line A12 Description	S	-
Schedule o Page Ref Fotal Note: Schedule o Fotal Othe	f Notes Pay Line Ref s Payable f Other Cu Line Ref	Description rrent Liabilities (Itemize) Page 33 Line A12 Description Liabilities (Itemize) ng-Term Liabilities (itemize) Page 34 Line B4	S	-
Schedule o Page Ref Fotal Note: Schedule o Fotal Othe	f Notes Pay Line Ref s Payable f Other Cu Line Ref	Description Trent Liabilities (Itemize) Page 33 Line A12 Description Liabilities (Itemize)	S	-
Schedule o Page Ref Fotal Note: Schedule o Fotal Othe	f Notes Pay Line Ref s Payable f Other Cu Line Ref	Description rrent Liabilities (Itemize) Page 33 Line A12 Description Liabilities (Itemize) ng-Term Liabilities (itemize) Page 34 Line B4	S	
Schedule o Page Ref Fotal Note: Schedule o Fotal Othe	f Notes Pay Line Ref s Payable f Other Cu Line Ref	Description rrent Liabilities (Itemize) Page 33 Line A12 Description Liabilities (Itemize) ng-Term Liabilities (itemize) Page 34 Line B4	S	-
Schedule o Page Ref Fotal Note: Schedule o Fotal Othe	f Notes Pay Line Ref s Payable f Other Cu Line Ref	Description rrent Liabilities (Itemize) Page 33 Line A12 Description Liabilities (Itemize) ng-Term Liabilities (itemize) Page 34 Line B4	S	-
Schedule o Page Ref Total Note: Schedule o Page Ref	f Notes Pay Line Ref s Payable f Other Cu Line Ref	Description rrent Liabilities (Itemize) Page 33 Line A12 Description Liabilities (Itemize) ng-Term Liabilities (itemize) Page 34 Line B4	S	-
Schedule o Page Ref Total Note: Schedule o Page Ref Total Othe Schedule o	f Notes Pay Line Ref s Payable f Other Cu Line Ref f Other Lo Line Ref	Description rrent Liabilities (Itemize) Page 33 Line A12 Description Liabilities (Itemize) ng-Term Liabilities (itemize) Page 34 Line B4	S	

G. Balance Sheet (cont'd)

Name of Faci	ame of Facility License No. Report for Year Ended		ıded		Page	of		
New Milford	Tew Milford Crossings, LLC / DBA Village C 2330 9/30/2018				33	37		
Account							Amou	ınt
Liabilities								
A.	Cu	rrent Liabilities						
	1.	Trade Accounts Payable				\$		552,061
	2.	Notes Payable (itemize)				\$		
		G G 1 1 1						
		See Schedule				Φ.		50.10 -
	3.	Loans Payable for Equipme			D . D	\$		62,407
		Name of Lender	Purpose	Amount	Date Due			
		M&T Bank	Equipment I am	62.407				
		M&I Bank	Equipment Loan	62,407				
	4.	Accrued Payroll (Exclusive	of Owners and/or Stoc	kholders only)		\$		201,829
	5.	Accrued Payroll (Owners a	nd/or Stockholders onl	y)		\$		
	6.	Accrued Payroll Taxes Pay	able			\$		
	7.	Medicare Final Settlement	Payable			\$		
	8.	Medicare Current Financin	g Payable			\$		
	9.	Mortgage Payable (Curren	t Portion)			\$		
	10.	Interest Payable (Exclusive	of Owner and/or Relat	ed Parties)		\$		
	11.	Accrued Income Taxes*				\$		
	12.	Other Current Liabilities (ii	temize)			\$		1,047,339
		Accounting Fees	26,640	Due to Third Party	33,380			
		Revenue Assessment	127,591	Patient Funds	25,391			
		Due to Related - Short Term		Accrued Expenses	61,940			
	757	Due to Realty		See Schedule		Φ		1.072.727
A-13.	10	tal Current Liabilities (Line	es A1 thru 12)			\$		1,863,636

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

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 o	of
New Milford Crossings, LLC / DBA Village	2330	9/30/2018			34 3'	7
	Account				Amount	
		Total Broug	ht Forward:		1,863,6	536
Liabilities (cont'd)						
B. Long-Term Liabilities						
1. Loans Payable-Equipment (1		\$	685,7	763
Name of Lender	Purpose	Amount	Date Due			
M&T Bank	Equipment Loan	685,763				
Mortgages Payable Loans from Owners or Rela	ted Parties (itemize)			\$ \$		
Name and Address of Lender	Amount	Loan Da		Ψ		
4. Other Long-Term Liabilitie	s (itemize)			\$	79,4	110
Due to Related - Long Term		84,620				
Net Deferred Tax Liability		(5,210)				
See Schedule						
B-5. Total Long-Term Liabilities (1		-		\$	765,1	
C. Total All Liabilities (Lines A-	(3 + B-5)			\$	2,628,8	309

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

	ne of Facility Milford Crossings, LLC / DBA V License No. Report for Year Ended 9/30/2018	Pag 35	ge of 37
nev	Account	33	Amount
A.	Reserves		Timount
	1. Reserve for value of leased land	\$	
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	\$	
	3. Reserve for depreciation value of leased personal property (<i>Equity</i>)	\$	
	4. Reserve for leasehold real properties on which fair rental value is based	\$	
	5. Reserve for funds set aside as donor restricted	\$	
	6. Total Reserves	\$	
B.	Net Worth		
	1. Owner's Capital	\$	
	2. Capital Stock	\$	
	3. Paid-in Surplus	\$	
	4. Treasury Stock	\$	
	5. Cumulated Earnings	\$	1,249,293
	6. Gain or Loss for Period 10/1/2017 thru 9/30/2018	\$	(360,208)
	7. Total Net Worth	\$	889,085
C.	Total Reserves and Net Worth	\$	889,085
D.	Total Liabilities, Reserves, and Net Worth	\$	3,517,894

CSP-36 Rev. 6/95

H. Changes in Total Net Worth

Name of	f Facility	License No.	Report for Year	Ended	Page	of
New Mi	ilford Crossings, LLC / DBA Vill	2330	9/30/2018		36	37
		Aı	nount			
A. Ba	alance at End of Prior Period as sh	nown on Report of 09/	/30/2017		\$	1,268,283
B. To	otal Revenue (From Statement of I	Revenue Page 30)			\$	8,331,615
C. To	otal Expenditures (From Statemen	nt of Expenditures Pag	ge 27)		\$	8,691,823
	et Income or Deficit				\$	(360,208)
	alance				\$	908,075
F. A	dditions					
1.	Additional Capital Contributed	(itemize)				
	CT Tax Refund		25,435			
2.	Other (itemize)					
F-3. To	otal Additions				\$	25,435
G. De	eductions				·	Ź
1.	Drawings of Owners/Operators/	Partners (Specify)			\$	
	Name and Address (No., City,	State, Zip)	Title	Amount		
	`	* /				
2	Other Withdrawings (Specify)		<u>ļ</u>		\$	44,425
2.	Purpose		Amou		Ψ	11,123
Commis	ssioner of Revenue		7 Hillot	15,714		
Prior Pe				28,711		
11101 FC	illou			20,/11		
2	Total Dadastiana		1		ф	44.425
3.		00/20/10			\$	44,425
Н. В	alance at End of Period	09/30/18			\$	889,085

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended Page of					
New Milford Crossings, LLC / DBA	2330	9/30/2018 37 37					
	Check appropriate category						
☐ Chronic and Convalescent Nursin Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)	□ (Specify)					
	Preparer/Reviewer Certifica	tion					
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		·					
Blum, Shapiro & Company, P.C. Addres Address	Phone Number						
2 Enterprise Drive, Shelton, CT 06484	860-561-6853						
Annual Report Contact	Phone Number						
George Thomas Annual Report Contact Email Address	860-561-6853						
Annual Report Contact Email Address							
GTHOMAS@blumshapiro.com							