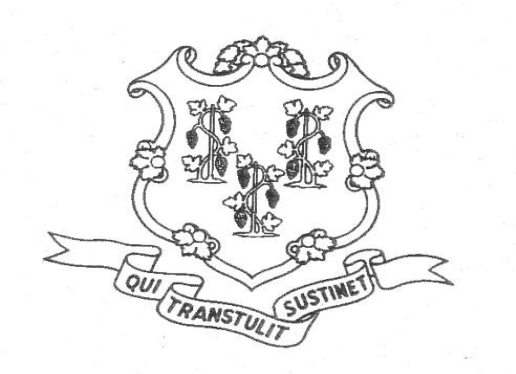
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2023

Name of Facility (as licensed) Ledgecrest Health Care Center		
Address (No. & Street, City, State, Zip Code) 154 Kensington Rd. Kensington, CT 06037		
Type of Facility ☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined	☐ (Specify)	☐ (Specify)
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023	

License Numbers:	CCNH / RHNS 2046 C	(Specify)	(Specify)	Medicare Provider 07-5230

Medicaid Provider Numbers:	CCNH / RHNS 220468	(Specify)	(Specify)

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	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 Ledgecrest Health Care Center [facility name], for the cost report period beginning October 1, 2022 and ending September 30, 2023, 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) Sarah Davies			Printed Name (Owner) Brian Foley	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Ledgecrest Health Care Center	Period Covered:		From 10/1/2022	To 9/30/2023
Address of Facility 154 Kensington Rd. Kensington, CT 06037				
Report Prepared By Apple Health Care, Inc.	Phone Number (860) 678-9755		Date	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
(860) 828-0583	9/30/2023	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Ledgecrest Health Care Center	154 Kensington Rd. Kensington, CT 06037

License Numbers:	CCNH / RHNS 2046 C	(Specify)	(Specify)	Medicare Provider No. 07-5230

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

○ Proprietorship ○ LLC ○ Partnership ◉ Profit Corp. ○ Non-Profit Corp. ○ Government ○ Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Sarah Davies	2028

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	3	37

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

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	3A	37

If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Ledgecrest Health Care Center	154 Kensington Rd. Kensington, CT 06037	Connecticut

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Brian Foley	21 Waterville Rd. Avon, CT 06001	President	100
Ryan Vess	21 Waterville Rd. Avon, CT 06001	Secretary	
Names of Stockholders Owning at Least 10% of Shares			
Brian Foley	21 Waterville Rd. Avon, CT 06001	President	100

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	3B	37

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	4	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ⊙ No

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Brian J. Foley	21 Waterville Rd. Avon, CT 06001	○	⊙		Real Estate Rental	Pg. 22 Line 9	264,000	264,000
Apple Health Care	21 Waterville Rd. Avon, CT 06001	○	⊙		Management & Accounting Services	Pg. 16 Line m12	185,580	185,580
Corporate Employees	21 Waterville Rd. Avon, CT 06001	○	⊙		Employee Staffing	Pg. 10 Schedule	133,406	133,406
Healthport	21 Waterville Rd. Avon, CT 06001	○	⊙		Employee Staffing	Pg. 10 Schedule	1,403	1,403
Employees @ various Apple facilities		○	⊙		Employee Staffing	Pg. 10 Schedule	97,855	97,855
Apple Health Care	21 Waterville Rd. Avon, CT 06001	○	⊙		Pension Plan (401K)	Pg. 15 Line 1a7	61,094	61,094
Lucent	424 Church St. Nashville, TN 37219	⊙	○		Group Medical	Pg. 15 Line 1a5	172,989	
Delta Dental	148 Eastern Blvd Glastonbury, CT 06033	⊙	○		Group Dental	Pg. 15 Line 1a5	11,944	
USI	PO Box 62937 Virginia Beach, VA 23466	⊙	○		Property, Liability, & Umbrella Insurance	Pg. 27 Line 14a	103,046	

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	4	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association ○ Yes ⊙ No

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Reliance Standard	2001 Market St. Philadelphia, PA	✠			Group Life & Disability	Pg. 15 1a6	1,935	
AIG	PO Box 10472 Newark, NJ	✠			Worker's Compensation	Pg. 15 1a1	88,497	
Swallowing Diagnotics	21 Waterville Road Avon, CT	✠		83%	Diagnostic Services	Pg 20 5f	1,800	1,697
Staffon Tap	76 Hartford Rd. Simsbury, CT		✠		Employee Staffing	Pg. 13 Line 11a1	10,137	10,137
Ryan Vess	21 Waterville Road Avon, CT		✠			##		
Tarah Foley	21 Waterville Road Avon, CT		✠			##		
Paula Meunier	21 Waterville Road Avon, CT		✠			##		
Kayla Foley	21 Waterville Road Avon, CT		✠			##		
Patricia Hyyppa	21 Waterville Road Avon, CT		✠			##		
Reino Hyyppa	21 Waterville Road Avon, CT		✠			##		
Robert Wooley	21 Waterville Road Avon, CT		✠			##		

* Use additional sheets if necessary.
** Provide the percentage amount of revenue received from non-related parties.
Related expense has been disallowed on Pg. 28 Line 23

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	5	37

If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (*See listing page 13*)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

The preparer of this report must answer the following questions applicable to the cost information provided.

1. In the preparation of this Report, were all costs allocated as required? ⊙ Yes ○ No If "No," explain fully why such allocation was not made.

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

The costs incurred by Apple Health Care, Inc. (a related party) to provide accounting and managerial services to each facility owned by Brian J. Foley are allocated on a per bed basis.

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

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

N/A

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General Information and Questionnaire
Other Lines of Business

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	6	37

Square footage of entire facility.	26,917

Outpatient Therapy

Does the Facility provide outpatient therapy services?	No

If yes, please complete the following:

	Square footage of therapy space.

Meals on Wheels

Does the facility provide Meals on Wheels?	No

If yes, please complete the following:

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

Apartments, Independent Living, Assisted Living

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

If yes, please complete the following:

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

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General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Ca	2046 C	9/30/2023	7	37

Child Day Care

Does the Facility provide Child Day Care?	No

If yes, please complete the following:

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

Adult Day Care

Does the Facility provide Adult Day Care?	No

If yes, please complete the following:

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

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH / RHNS Level	Total (Specify)	Total (Specify)	Period 10/1 Thru 6/30 Total	Period 10/1 Thru 6/30 CCNH / RHNS	Period 10/1 Thru 6/30 (Specify)	Period 10/1 Thru 6/30 (Specify)	Period 7/1 Thru 9/30 Total	Period 7/1 Thru 9/30 CCNH / RHNS	Period 7/1 Thru 9/30 (Specify)	Period 7/1 Thru 9/30 (Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	60	60			60	60						
B. On last day of THIS report period	60	60							60	60		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	45	45			45	45						
B. As of midnight of THIS report period	42	42							42	42		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,546	1,546			1,056	1,056			490	490		
B. Medicaid (Conn.)	12,660	12,660			9,783	9,783			2,877	2,877		
C. Medicaid (other states)												
D. Private Pay	2,801	2,801			1,858	1,858			943	943		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	17,007	17,007			12,697	12,697			4,310	4,310		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	17,007	17,007			12,697	12,697			4,310	4,310		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	9	37

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

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH / RHNS	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	(Specify)	R.C.H.	ICF-MR
No. of Residents	1	31		10				
Per Diem Rate								
a. One bed rm.				400.00				
b. Two bed rms.	RUGS	######		350.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B	5,253	5,253			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other	10,315	10,315			
D. ***Total Physical Therapy Treatments***	15,568	15,568			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	517	517			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other	1,512	1,512			
D. ***Total Speech Therapy Treatments***	2,029	2,029			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	4,821	4,821			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other	8,130	8,130			
D. ***Total Occupational Therapy Treatments***	12,951	12,951			

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	10	37

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

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
A. Salaries and Wages*									
1. Operators/Owners (Complete also Sec. I of Schedule A1)									
2. Administrator(s) (Complete also Sec. III of Schedule A1)	120,430		2,046						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)									
5. Dietary Service									
a. Head Dietitian	11,062		256						
b. Food Service Supervisor	62,355		2,109						
c. Dietary Workers	250,417		12,311						
6. Housekeeping Service									
a. Head Housekeeper	69,983		2,329						
b. Other Housekeeping Workers	84,280		5,256						
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance									
b. Other Maintenance Workers	92,680		3,199						
8. Laundry Service									
a. Supervisor									
b. Other Laundry Workers									
9. Barber and Beautician Services									
10. Protective Services									
11. Accounting Services									
a. Head Accountant									
b. Other Accountants	64,049		2,396						
12. Professional Care of Residents									
a. Directors and Assistant Director of Nurses	124,595		1,872						
b. RN									
1. Direct Care	570,858		9,839						
2. Administrative**	102,344		2,038						
c. LPN									
1. Direct Care	276,022		7,567						
2. Administrative**									
d. Aides and Attendants	893,319		38,207						
e. Physical Therapists	205,861		4,840						
f. Speech Therapists	36,678		731						
g. Occupational Therapists	165,367	(165,367)	4,012						
h. Recreation Workers	89,656		3,938						
i. Physicians									
1. Medical Director									
2. Utilization Review									
3. Resident Care***									
4. Other (Specify)									
j. Dentists									
k. Pharmacists									
l. Podiatrists									
m. Social Workers/Case Management	51,523	(6,055)	2,152						
n. Marketing									
o. Other (Specify) See Attached Schedule									
A-13. Total Salary Expenditures	3,271,478	(171,422)	105,097						

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH / RHNS			(Specify)			(Specify)		
Position	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**
Total	$ -	$ -	-	$ -	$ -	-	$ -	$ -	-

Schedule of Other Fees (Page 13)

	CCNH / RHNS			(Specify)			(Specify)		
Service	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**
Employee Relations Consultant	$ 500		7						
A&D Fee	$ 2,036		27						
Total	$ 2,536	$ -	34	$ -	$ -	-	$ -	$ -	-

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

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	11	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	(Specify)	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	(Specify)	(Specify)							
Section III - Administrators* **										
Sarah Davies	120,430				Administrator 10/1/22 - 9/30/23	2,046	A2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	13	37

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)									
1. Dietitian									
2. Dentist	6,247		83						
3. Pharmacist	6,854		91						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care									
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	18,700	(18,700)							
b. Utilization Review (Title 18 and 19 only) monthly meeting									
c. Resident Care**									
d. Administrative Services facility									
1. Infection Control Committee (Quarterly meetings)									
2. Pharmaceutical Committee (Quarterly meetings)									
3. Staff Development Committee (Once annually)									
e. Other (Specify)									
9. Speech Therapist									
a. Resident Care	1,800		24						
b. Other									
10. Occupational Therapist									
a. Resident Care									
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	10,137		138						
2. Administrative***									
b. LPN									
1. Direct Care									
2. Administrative***									
c. Aides									
d. Other									
12. Other (Specify)									
See Attached Schedule	2,536		34						
B-13 Total Fees Paid in Lieu of Salaries	46,273	(18,700)	371						

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Starling Physicians 1260 Silas Deane Hwy, Wethersfield, CT 06109	Medical Director	○	⊙	
HealthDrive Dental 888 Worcester St, Wellesley, MA 02482	Dentist	○	⊙	
Bamboo Health, Inc. 9901 Linn Station Rd, STE 500 Louisville, KY 40223	Admissions/Discharge Fee	○	⊙	
Neighborcare, Dept 781668, Detroit, MI	Pharmacist	○	⊙	
Mary B Jordon 75 High Farms Rd W. Hartford CT	Employee Relations Consultant	○	⊙	
Swallowing Diagnostic 21 Waterville Rd. Avon. CT	Speech Consultant	⊙	○	See Pg. 4
Staffon Tap 76 Hartford Rd. Simsbury, CT	Employee Staffing	⊙	○	See Pg. 4
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended					Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023					15	37

Item	Total Including Adjustment	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
1. Administrative and General							
a. Employee Health & Welfare Benefits							
1. Workmen's Compensation $	88,497	88,497					
2. Disability Insurance $							
3. Unemployment Insurance $	26,851	26,851					
4. Social Security (F.I.C.A.) $	226,201	226,201					
5. Health Insurance $	160,079	160,079					
6. Life Insurance (employees only)							
(not-owners and not-operators) $	1,935	1,935					
7. Pensions (Non-Discriminatory) $	61,094	61,094					
(not-owners and not-operators)							
8. Uniform Allowance $							
9. Other (*Specify*) $							
See Attached Schedule							
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)* $							
c. Bad Debts* $		17,225	(17,225)				
d. Accounting and Auditing $	4,156	10,039	(5,883)				
e. Legal (*Services should be fully described on Page 15b)* $							
f. Insurance on Lives of Owners and Operators (*Specify*)* $							
g. Office Supplies $	5,884	6,042	(158)				
h. Telephone and Cellular Phones							
1. Telephone & Pagers $	27,446	27,446					
2. Cellular Phones $							
i. Appraisal (*Specify purpose and attach copy*)* $							
j. Corporation Business Taxes (*franchise tax*) $							
k. Other Taxes (*Not related to property - See Page 22)*							
1. Income* $	(12,846)	(12,846)					
2. Other (*Specify*) $							
See Attached Schedule							
3. Resident Day User Fee $	322,826	322,826					
Subtotal $	912,123	935,389	(23,266)				

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	15b	37

The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

	Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1	Clifton Larson Allen LLP (CLA)	29 South Main Street West Hartford, CT 06127
2	Brazee & Huban	35 Wendell Ave. Pittsfield, MA 10202
3	Clifton Larson Allen LLP (CLA)	29 South Main Street West Hartford, CT 06127
4		

Services Provided by This Firm (*describe fully*)

1	Preparation of audited financials	$ 5,883
2	Preparation of Tax Returns	$ 3,181
3	Audit 401K	$ 975
4		$
		Charge for Services Provided $ 10,039

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

⊙ Yes ○ No — Pg. 15 Line 1d

Legal Services Information

	Name of Legal Firm or Independent Attorney	Telephone Number
1		
2		
3		
4		
5		

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1		$
2		$
3		$
4		$
5		$
		Charge for Services Provided $

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

⊙ Yes ○ No — Pg. 15 1e

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

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	16	37

Item		Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:		912,123	935,389	(23,266)				
l. Travel and Entertainment								
1. Resident Travel and Entertainment	$							
2. Holiday Parties for Staff	$	840	840					
3. Gifts to Staff and Residents	$	(0)	7,784	(7,784)				
4. Employee Travel	$	3,762	3,762					
5. Education Expenses Related to Seminars and Conventions	$	3,747	3,747					
6. Automobile Expense (*not purchase or depreciation*)	$							
7. Other (*Specify*)	$							
See Attached Schedule								
m. Other Administrative and General Expenses								
1. Advertising Help Wanted (*all such expenses*)	$	357	357					
2. Advertising Telephone Directory (*all such expenses*)***	$							
3. Advertising Other (*Specify*)***	$	(0)	3,446	(3,446)				
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	$	799	799					
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	4,786	4,786					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$							
9. Subscriptions	$	462	462					
10. Contributions*** 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**	$	185,580	185,580					
13. Other (*Specify*) See Attached Schedule	$	33,757	80,542	(46,785)				
C-14 Total Administrative & General Expenditures	$	1,146,212	1,227,494	(81,281)				

* Do not include Subscriptions, which should go in item 9.
** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
*** Facility should self-disallow the expensein the Adjustment column.

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Advertising - Public Relations	$ 3,446	$ (3,446)				
Total Other Advertising	$ 3,446	$ (3,446)	$ -	$ -	$ -	$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
CAHCF	$ 4,786					
Total Dues	$ 4,786	$ -	$ -	$ -	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Corporate Fees - Non Reimbursable	$ 44,046	$ (44,046)				
Licenses & Fees	$ 1,513					
Pre Employment Screenings	$ 1,218					
System License & Subscription Fees	$ 31,026					
Bank Service Charges	$ 2,234	$ (2,234)				
Legal Fees - Collection/Probate	$ -					
IT Service Fees	$ -					
Resident Expenses	$ 321	$ (321)				
Survey Fines & Citations	$ -					
Healthport Indirect	$ -					
User Fees	$ 184	$ (184)				
Total Other Administrative and General	$ 80,542	$ (46,785)	$ -	$ -	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Ledgecrest Health Care Center	2046 C	9/30/2023	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 #
Apple Health Care, Inc.	185,580	Accounting and Management Services	Pg. 16 Line m12

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	18	37

Item		Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	$	142,710	142,710					
2. Non-Food Supplies	$	23,857	23,857					
3. Other (*Specify*)_____	$							
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	1,540	1,540					
c. Other (*Specify*)_____	$							
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	168,108	168,108					

2E. Dietary Questionnaire	Total	CCNH / RHNS	(Specify)	(Specify)	
F. Resident Meals: Total no. of meals served per day:*	140	140			

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	19	37

Item		Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
3. Laundry								
a. In-House Processing*	Lbs.							
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $	2,000	2,000					
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.							
	Amt. $							
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.							
	Amt. $							
4. Repair and/or purchase of linens.***	Lbs.							
	Amt. $	845	845					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	49,964	49,964					
c. Other (*Specify*)	$							
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	52,808	52,808					

3E.	Laundry Questionnaire			
F.	Is cost of employee laundry included in 3D?	○ Yes	⊙ No	If yes, specify cost.
G.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
H.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)		
I.	Is Cost of laundry provided to persons other than employees or residents included in 3D?	○ Yes	⊙ No	If yes, specify cost.
J.	Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
K.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)		

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3D.

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

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

Name of Facility	License No.	Report for Year Ended					Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023					20	37

Item			Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4. Housekeeping	Sq. Ft. Serviced by Personnel		26,917	26,917					
a. In-House Care									
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	15,008	15,008					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel								
	Amt.	$							
C. Other (*Specify*)		$							
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	15,008	15,008					
5. Resident Care (Supplies)**									
a. Prescription Drugs***									
1. Own Pharmacy		$							
2. Purchased from Neighborcare		$	2,481	51,868	(49,387)				
b. Medicine Cabinet Drugs		$							
c. Medical and Therapeutic Supplies		$	94,631	94,631					
d. Ambulance/Limousine***		$							
e. Oxygen									
1. For Emergency Use		$							
2. Other***		$	5,126	6,655	(1,530)				
f. X-rays and Related Radiological Procedures***		$	(0)	3,153	(3,153)				
g. Dental (*Not dentists who should be included under salaries or fees*)		$							
h. Laboratory***		$	(0)	11,338	(11,338)				
i. Recreation		$	8,677	8,677					
j. Direct Management Services*		$							
k. Indirect Management Services*		$							
l. Cable TV		$	13,447	13,447					
m. Other (Specify)**** See Attached Schedule		$	0	16,736	(16,736)				
n. Physical Therapy Expense		$							
o. Speech Therapy Expense		$							
5P. ***Total Resident Care Expenditures*** (5a - 5o)		$	124,361	206,504	(82,144)				

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

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

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

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

Schedule of Other Resident Care

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Nursing Station Supplies	$ -					
IV Therapy	$ 2,727	$ (2,727)				
Rehab Service & Supplies	$ 14,009	$ (14,009)				
Total Other Resident Care	$ 16,736	$ (16,736)	$ -	$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH / RHNS	(Specify)	(Specify)	Pg	Line
CWPM	25 Norton Pl. Plainville, CT 06062	○	⊙		Refuse Removal	17,098			22	6f
Unitex	161 S Macquesten Pkwy Mt Vernon, NY 10550	○	⊙		Laundry Purchased Services	49,964			19	4b
EMSL Analytical, Inc.	200 Route 130 North Cinnaminson, NJ 08077	○	⊙		Water Testing Services	17,612			22	6a
Facilities Compliance Services LLC	1492 Berlin Turnpike Berlin, CT 06037	○	⊙		Maintenance and Repair	44,855			22	6a
West State Mechanical	PO Box 1045 Torrington, CT 06790	○	⊙		Maintenance and Repair	17,808			22	6a
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

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

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

Name of Facility	License No.	Report for Year Ended					Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023					22	37
Item		Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	$	174,595	174,595					
b. Heat	$	28,317	28,317					
c. Light & Power	$	36,748	36,748					
d. Water	$	19,716	19,716					
e. Equipment Lease (*Provide detail on page 22b*)	$							
f. Other (*itemize*)	$	18,509	18,509					
See Attached Schedule								
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	277,885	277,885					
7. Depreciation (*complete schedule page 23**)								
a. Land Improvements	$							
b. Building & Building Improvements	$							
c. Non-Movable Equipment	$							
d. Movable Equipment	$	282	282					
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	282	282					
8. Amortization (*Complete att. Schedule Page 24**)								
a. Organization Expense	$							
b. Mortgage Expense	$							
c. Leasehold Improvements	$	4,797	4,797					
d. Other (*Specify*)	$							
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	4,797	4,797					
9. Rental payments on leased real property less real estate taxes included in item 10b	$	264,000	264,000					
10. Property Taxes								
a. Real estate taxes paid by owner	$							
b. Real estate taxes paid by lessor	$	47,551	47,551					
c. Personal property taxes	$	4,198	4,198					
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	320,828	320,828					

* 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	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Refuse Removal	$ 18,509					
Total Other Repairs and Maintenance	$ 18,509	$ -	$ -	$ -	$ -	$ -

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General Information and Questionnaire
Leases (Excluding Real Property)

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

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

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

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

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
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Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	39,287		39,287	39,287	S\L	Var		
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					145,236		145,236	145,236	S\L	Var		
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative					6,527		6,527		S\L	Var	282	
d. Standard Resident												
e. Specialized Resident												
Total Acquired during this report period					6,527		6,527				282	
D-3. Subtotal												282
E. ***Total Depreciation***												282

Schedule of Land Improvements Acquired during this report period

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

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

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

Schedule of Building Improvements Acquired during this report period

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

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

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

Schedule of Non-Movable Equipment Acquired during this report period

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

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One Movable Category	Cost	Useful Life	Depreciation	
Additions:						
1/25/2023	Water Booster for Dish Machine	Administrative	$ 2,785	ME-5	$ 204	
7/27/2023	Ice Maker	Administrative	$ 3,742	ME-10	$ 78	
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
Total additions for Movable Equipment			$ 6,527		$ 282	*
Deletions:						
Total deletions for Movable Equipment			$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
9/28/2023	Fire Alarm Repair	$ 2,149	LHI-10	$ 3	
Total additions for Leasehold Improvement		$ 2,149		$ 3	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period				511,832	489,570	A		4,793	
2. Disposals (attach schedule)									
3. Acquired during this report period									
(attach schedule)				2,149				3	
C-4. Subtotal									4,797
D. ***Total Amortization***									4,797

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ⊙ Yes ○ No

If "Yes," complete Part B.
If "No," complete Part C.

*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	60
6. Square Footage	26,917
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	04/21/22			
c. Interest Rate for the Cost Year	4.50%			
d. Term of Mortgage (number of years)	25			
e. Amount of Principal Borrowed	1,701,923			
f. Principal balance outstanding as of _____	1,640,841			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	26	37

Item	Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage $							
Name of Lender / Rate							
Address of Lender							
2. Second Mortgage $							
Name of Lender / Rate							
Address of Lender							
3. Third Mortgage $							
Name of Lender / Rate							
Address of Lender							
4. Fourth Mortgage $							
Name of Lender / Rate							
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount $							
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expense							
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5) $							

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	27	37

Item	Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:							
12. C. Movable Equipment 1. Automotive Equipment $							
A. Item / Rate / Amount							
Lender							
Address of Lender							
2. Other (*Specify*) $							
A. Item / Rate / Amount							
Lender							
Address of Lender							
B. Item / Rate / Amount							
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $							
12. D. Other Interest Expense (*Specify*) $							
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $							
14. Insurance							
a. Insurance on Property (buildings only) $	103,046	103,046					
b. Insurance on Automobiles $							
c. Insurance other than Property (as specified above) 1. Umbrella (*Blanket Coverage*) $							
2. Fire and Extended Coverage $							
3. Other (*Specify*) $							
14d. ***Total Insurance Expenditures (14a + b + c)*** $	103,046	103,046					
15. ***Total All Expenditures (A-13 thru C-14)*** $	5,335,886	5,689,434	(353,547)				

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Ledgecrest Health Care Center	2046 C	9/30/2023	30 | 37

Item		Total	CCNH / RHNS	(Specify)	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	3,149,829	3,149,829		
b. Medicaid Room and Board Contractual Allowance **	$				
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	572,891	572,891		
b. Medicare Room and Board Contractual Allowance **	$	269,262	269,262		
4. a. Private-Pay Residents and Other	$	1,119,242	1,119,242		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	31,367	31,367		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(30,676)	(30,676)		
c. Prescription Drugs - Non-Medicare	$	4,287	4,287		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(4,287)	(4,287)		
2. a. Medical Supplies - Medicare	$	107	107		
b. Medical Supplies - Medicare Contractual Allowance **	$	(107)	(107)		
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	397,325	397,325		
b. Physical Therapy - Medicare Contractual Allowance **	$	(364,314)	(364,314)		
c. Physical Therapy - Non-Medicare	$	147,542	147,542		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(58,375)	(58,375)		
4. a. Speech Therapy - Medicare	$	63,530	63,530		
b. Speech Therapy - Medicare Contractual Allowance **	$	(59,351)	(59,351)		
c. Speech Therapy - Non-Medicare	$	24,150	24,150		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(11,405)	(11,405)		
5. a. Occupational Therapy - Medicare	$	433,120	433,120		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(394,168)	(394,168)		
c. Occupational Therapy - Non-Medicare	$	149,455	149,455		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(38,850)	(38,850)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	5,400,574	5,400,574		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	1	1		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	139,152	139,152		
V. Total Other Revenue (1 thru 8)	$	139,153	139,153		
VI. Total All Revenue (III +V)	$	5,539,727	5,539,727		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
Total Other Resident Revenue		$ -	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	(Specify)
Pg 30 IV5	Account Receivable Interest	311,014	$ 1		
Total Interest Income			$ 1	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
30 IV8	Optum	$ 14,165		
30 IV8	Rebates	$ 9,519		
30 IV8	West River	$ 20,685		
30 IV8	Medical Records	$ 158		
30 IV8	Covid Deferred Revenue	$ 94,625		
Total Other Revenue		$ 139,152	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 300
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 311,014
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 185
4 Inventories				$ 7,566
5. Prepaid Expenses				$ 14,787
a.				
b.				
c.				
d. See Schedule		14,787		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 621,148
See Schedule		621,148		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 955,001
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost			$
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	513,981		$ 19,615
	Accum. Depreciation	494,366	Net	
5. Non-Movable Equipment	*Historical Cost	39,287		$
	Accum. Depreciation	39,287	Net	
6. Movable Equipment	*Historical Cost	151,763		$ 6,245
	Accum. Depreciation	145,518	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 25,860

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	A5	Prepaid Insurance	$ -
31	A5	Prepaid Propert Tax	$ 14,787
31	A5	Other Prepaid Expenses	$ -
Total Prepaid Expenses			$ 14,787

Schedule of Other Current Assets (itemized) Page 31 Line A8

Page Ref	Line Ref	Description	
		Exchange Accounts (10401 - 10403) (Debit Balance)	
		Due Affiliate (Debit Balance)	$ 619,705
		AP Patient Exchange	$ 1,443
Total Other Current Assets (Itemize)			$ 621,148

Schedule of Other Fixed Assets (Itemize) Page 31 Line B9

Page Ref	Line Ref	Description	
31	B9	Fixed Asset Clearing Account	$ -
31	B9	Capitalized Refinance Expense	$ -
31	B9	Construction in Progress	$ -
Total Other Other Fixed Assets (Itemize)			$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
32	D7	Leasehold Deposits	$ -
32	D7	Deferred Tax Asset	$ 67,105
Total Other Assets			$ 67,105

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

Page Ref	Line Ref	Description	
		Due Affiliate (Credit Balance	
		Exchange Accounts (10401-10403) (Credit Balance)	
		Accrued PTO	$ 116,722
		Payroll W/H	$ 7,052
		Accrued Professional Fees	$ 17,970
		Prepaid Income Tax	$ 2,412
		Accrued Worker's Comp	$ 114,750
		Accrued Group Insurance	$ 37,374
		Accrued Other Expense	$ 247,252
Total Other Current Liabilities (Itemize)			$ 543,533

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

Page Ref	Line Ref	Description	
		A/P Other (Intercompany)	$ 744,047
		Dostie Note	$ -
		Marlin Capital Lease	$ -
		Loan Payable Officer	$ -
		Security Deposit/Deferred Revenue	$ -
		Deferred Income Tax Payable	$ -
		State Income Tax Payable	$ 39,210
		L/T Accrued Other Expenses	$ -
Total Other Current Liabilities (Itemize)			$ 783,257

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	32	37

Account				Amount
			Total Brought Forward:	$ 980,860
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 67,105
See Schedule		67,105		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 67,105
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 1,047,965

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 292,862
	2. Notes Payable (*itemize*)				$
	See Schedule				
	3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
	Name of Lender	Purpose	Amount	Date Due	
	4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 62,847
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 7,866
	7. Medicare Final Settlement Payable				$
	8. Medicare Current Financing Payable				$
	9. Mortgage Payable (*Current Portion*)				$
	10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
	11. Accrued Income Taxes*				$
	12. Other Current Liabilities (*itemize*)				$ 543,533
	See Schedule		543,533		
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 907,108

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	34	37

Account				Amount
			Total Brought Forward:	907,108
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				$
3. Loans from Owners or Related Parties (*itemize*)				$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (*itemize*)				$ 783,257
See Schedule	783,257			
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ 783,257
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 1,690,366

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

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$ 4,263,186
	2. Capital Stock	$ 1,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (5,110,428)
	6. Gain or Loss for Period 10/1/2022 thru 9/30/2023	$ 203,841
	7. Total Net Worth	$ (642,401)
C.	***Total Reserves and Net Worth***	$ (642,401)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 1,047,965

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2022			$ (1,026,689)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 5,539,727
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 5,335,886
D.	Net Income or Deficit			$ 203,841
E.	Balance			$ (822,848)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Brian Foley	185,000		
	2. Other (*itemize*)			
F-3.	Total Additions			$ 185,000
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$ 4,553
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	Brian Foley	President	4,553	
	2. Other Withdrawings *(Specify)*			$
	Purpose	Amount		
	3. Total Deductions			$ 4,553
H.	***Balance at End of Period*** 09/30/23			$ (642,401)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046 C	9/30/2023	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
Robert Gwizdak

Addres Address	Phone Number
21 Waterville Road Avon, CT 06001	(860) 678-9755

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Susan Southey	(860) 470-7542

Contact Email Address
ssouthey@apple-rehab.com