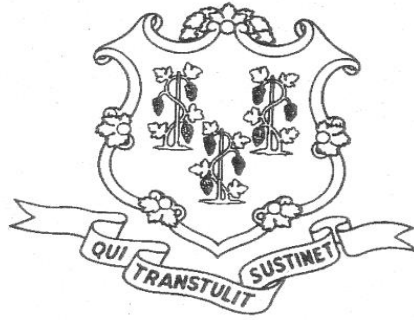


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2023

Name of Facility (as licensed) Leeway, Inc.	
Address (No. & Street, City, State, Zip Code) 40 Albert Street, New Haven, CT	
Type of Facility Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input checked="" type="checkbox"/> NurseFac-Aids <input checked="" type="checkbox"/> Residential Care Home	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

License Numbers:	CCNH / RHNS	NurseFac-Aids 2167-C	Residential Care Home 1891-RCH	Medicare Provider 07-5408
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Medicaid Provider Numbers:	CCNH / RHNS	NurseFac-Aids 42169	Residential Care Home
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**General Information**

Name of Facility (as licensed) Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2023	Page 1	of 37
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**Administrator's/Owner's Certification**

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Leeway, Inc. [facility name], for the cost report period beginning October 1, 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) Jay Katz			Printed Name (Owner) William Dyson , Chairman		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Leeway, Inc.		Period Covered:	From 10/1/2022	To 9/30/2023
Address of Facility 40 Albert Street, New Haven, CT				
Report Prepared By Robert Morgan, CPA		Phone Number 941 303-3958	Date 2/15/2024	
Item	Total	CCNH / RHNS	NurseFac- Aids	Residentia l Care Home
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (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**

Phone No. of Facility 203 865-0068		Report for Year Ended 9/30/2023	Page 2	of 37
Name of Facility (as shown on license) Leeway, Inc.		Address (No. & Street, City, State, Zip) 40 Albert Street, New Haven, CT		
License Numbers:	CCNH / RHNS 2167-C	NurseFac-Aids 1891-RCH	Residential Care Home 1891-RCH	Medicare Provider No. 07-5408
Type of Facility (Check appropriate box(es)) Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input checked="" type="checkbox"/> NurseFac-Aids <input checked="" type="checkbox"/> Residential Care Home				
Type of Ownership (Check appropriate box) <input type="checkbox"/> Proprietorship <input type="checkbox"/> LLC <input type="checkbox"/> Partnership <input type="checkbox"/> Profit Corp. <input checked="" type="radio"/> Non-Profit Corp. <input type="checkbox"/> Government <input type="checkbox"/> 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? <input type="radio"/> Yes <input checked="" type="radio"/> No                            If "Yes," explain fully.				
<b>Administrator</b>				
Name of Administrator Jay Katz		Nursing Home Administrator's License No.:	002085	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		



**General Information and Questionnaire**  
**Corporate Owners**

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2023	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation Leeway, Inc.	Business Address 40 Albert St., New Haven, Ct	State(s) in Which Incorporated Connecticut		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
William Dyson		Chairman		
Patricia Comer, Vice Chairperson		Vice Chairperson		
Russell Barbour, PhD				
Stuart Sidle, PhD				
Kathryn, Sylvester, Esq.				
Names of Stockholders Owning at Least 10% of Shares				
Frederick Streets, PhD				
Jeffrey Busk				
Elaine Anderson				
Robert Morgan, CPA				
Michael Dunn, Esq.				





**General Information and Questionnaire  
 Related Parties\***

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2023	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?  Yes  No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Robert Morgan, CPA		<input type="radio"/>	<input checked="" type="radio"/>		Cost Reporting and reimbursement	10, A.4	15,642	15,642
Michael Dunn, Esq., Greentree Risk Management		<input checked="" type="radio"/>	<input type="radio"/>	98%	Labor Relations Risk Management	15, 1.e	3,000	3,000
Leeway Welton Housing		<input type="radio"/>	<input checked="" type="radio"/>		Grant Program office space rental			
Leeway Putnam Housing		<input type="radio"/>	<input checked="" type="radio"/>		Grant Program office space rental			
Leeway Scattered Site Housing		<input type="radio"/>	<input checked="" type="radio"/>		None			
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

\* Use additional sheets if necessary.  
 \*\* Provide the percentage amount of revenue received from non-related parties.

**General Information and Questionnaire**  
**Basis for Allocation of Costs**

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2023	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.  
 Costs associated with management oversight of housing and grants has been eliminated from the cost report along with direct costs associated with each grant program. The details are included on the general ledger cross reference schedule included with the cost report submission.

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

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

**General Information and Questionnaire**  
**Other Lines of Business**

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2023	Page 6	of 37
Square footage of entire facility.		44,269		
<b>Outpatient Therapy</b>				
Does the Facility provide outpatient therapy services?		No		
<i>If yes, please complete the following:</i>				
Square footage of therapy space.				
<b>Meals on Wheels</b>				
Does the facility provide Meals on Wheels?		No		
<i>If yes, please complete the following:</i>				
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?			
<i>If yes, please state where costs are reported.</i>				
No	Are drivers for the program included in the facility's payroll?			
<i>If yes, please complete the following:</i>				
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				
<b>Apartments, Independent Living, Assisted Living</b>				
Does the facility have apartments, independent living, and/or assisted living?		No		
<i>If yes, please complete the following:</i>				
Square footage of apartments				
Square footage of independent living				
Square footage of assisted living				
Please identify the services provided:				

**General Information and Questionnaire**  
**Other Lines of Business (Continued)**

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2023	Page 7	of 37
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**Child Day Care**

Does the Facility provide Child Day Care?  No

*If yes, please complete the following:*

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

**Adult Day Care**

Does the Facility provide Adult Day Care?  No

*If yes, please complete the following:*

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

### Schedule of Resident Statistics

Name of Facility Leeway, Inc.			License No. 2167-C		Report for Year Ended 9/30/2023				Page 8	of 37		
	Total All Levels	Total CCNH / RHNS Level	Total	Total Residential Care Home	Period 10/1 Thru 6/30			Period 7/1 Thru 9/30				
					Total	CCNH / RHNS	NurseFac-Aids	Residential Care Home	Total	CCNH / RHNS	NurseFac-Aids	Residential Care Home
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	60		30	30	60		30	30				
B. On last day of THIS report period												
2. Number of Residents												
A. As of midnight of PREVIOUS report period	60		30	30	60		30	30				
B. As of midnight of THIS report period												
3. Total Number of Days Care Provided During Period												
A. Medicare	1,199		1,199		988		988		211		211	
B. Medicaid (Conn.)	19,585		9,449	10,136	14,497		6,988	7,509	5,088		2,461	2,627
C. Medicaid (other states)												
D. Private Pay	274			274	272			272	2			2
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	21,058		10,648	10,410	15,757		7,976	7,781	5,301		2,672	2,629
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. <b>Total Resident Days (3G + 4A + 4B)</b>	21,058		10,648	10,410	15,757		7,976	7,781	5,301		2,672	2,629

### Schedule of Resident Statistics (Cont'd)

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2023	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?  Yes  No  
 If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change	
	CCNH / RHNS	NurseFac-Aids	Residential Care Home	Lost			Gained			CCNH / RHNS	NurseFac-Aids	Residential Care Home		
	(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	NurseFac-Aids	Residential Care Home
1st change			
2nd change			
3rd change			
4th change			

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH / RHNS	CCNH / RHNS	NurseFac-Aids	CCNH / RHNS	NurseFac-Aids	Residential Care Home	R.C.H.	ICF-MR
No. of Residents	3		26			1	29	
Per Diem Rate								
a. One bed rm.	Various							
b. Two bed rms.	N/A		N/A		N/A	N/A	N/A	
c. Three or more bed rms.	N/A		N/A		N/A	N/A	N/A	

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	NurseFac-Aids	Outpatient	Residential Care Home
A. Medicare - Part B	148	148			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments	509	509			
C. Other	1,078	1,078			
<b>D. Total Physical Therapy Treatments</b>	<b>1,735</b>	<b>1,735</b>			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	32	32			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments	70	70			
C. Other	66	66			
<b>D. Total Speech Therapy Treatments</b>	<b>168</b>	<b>168</b>			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	86	86			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments	245	245			
C. Other	757	757			
<b>D. Total Occupational Therapy Treatments</b>	<b>1,088</b>	<b>1,088</b>			

**Annual Report of Long-Term Care Facility**

CSP-10 Rev. 3/2023

**Report of Expenditures - Salaries & Wages**

Name of Facility		License No.		Report for Year Ended			Page		of	
Leeway, Inc.		2167-C		9/30/2023			10		37	
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No										
Total Cost and Hours										
Item	CCNH / RHNS	Adjustment	Hours	NurseFac-Aids	Adjustment	Hours	Residential Care Home	Adjustment	Hours	
<b>A. Salaries and Wages*</b>										
1. Operators/Owners (Complete also Sec. I of Schedule A1)										
2. Administrator(s) (Complete also Sec. III of Schedule A1)				117,559		1,435	38,298		457	
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)										
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)				94,753		3,929	16,529		602	
5. Dietary Service										
a. Head Dietitian										
b. Food Service Supervisor										
c. Dietary Workers										
6. Housekeeping Service										
a. Head Housekeeper										
b. Other Housekeeping Workers										
7. Repairs & Maintenance Services										
a. Engineer or Chief of Maintenance				73,099		1,144	55,452		868	
b. Other Maintenance Workers				33,082		1,183	25,095		897	
8. Laundry Service										
a. Supervisor										
b. Other Laundry Workers										
9. Barber and Beautician Services										
10. Protective Services				112,846		7,229	85,604		5,484	
11. Accounting Services										
a. Head Accountant										
b. Other Accountants				261,733		6,643	85,266		2,164	
12. Professional Care of Residents										
a. Directors and Assistant Director of Nurses				138,389		2,080				
b. RN										
1. Direct Care				390,391		10,589				
2. Administrative**				149,050		2,948				
c. LPN										
1. Direct Care				254,870		3,964				
2. Administrative**										
d. Aides and Attendants				454,300		24,541	354,074		15,893	
e. Physical Therapists				152,319		2,715				
f. Speech Therapists				8,768		560				
g. Occupational Therapists				40,027	(40,027)	819				
h. Recreation Workers				51,154		2,001	17,051		667	
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				138,683		4,170	24,513		774	
n. Marketing										
o. Other (Specify) See Attached Schedule				3,304		304	3,312		296	
<i>A-13. Total Salary Expenditures</i>				2,474,327	(40,027)	76,254	705,194		28,102	

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

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

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

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH / RHNS			NurseFac-Aids			Residential Care Home		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
Chaplan				\$ 3,304		304	\$ 3,312		296
<b>Total</b>	\$ -	\$ -	-	\$ 3,304	\$ -	304	\$ 3,312	\$ -	296

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Schedule of Other Fees (Page 13)

Service	CCNH / RHNS			NurseFac-Aids			Residential Care Home		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
<b>Total</b>	\$ -	\$ -	-	\$ -	\$ -	-	\$ -	\$ -	-

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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	
Leeway, Inc.				2167-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	NurseFac-Aids	Residential Care Home							
<b>Section I - Operators/Owners</b>										
<b>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).</b>										

\* 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.

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page	of
Leeway, Inc.				2167-C		9/30/2023			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	NurseFac-Aids	Residential Care Home							
<b>Section III - Administrators***</b>										
Jay Katz		117,559	38,298	Std. Employee	Day to day oversight	1,903		Housing & Grants	177	12,568
<b>Section IV - Assistant Administrators</b>										

\*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.

**B. Report of Expenditures - Professional Fees**

Name of Facility	License No.	Report for Year Ended						Page	of
Leeway, Inc.	2167-C	9/30/2023						13	37
Total Cost and Hours									
Item	CCNH / RHNS	Adjustment	Hours	NurseFac-Aids	Adjustment	Hours	Residential Care Home	Adjustment	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>									
1. Dietitian				6,473		108	6,292		105
2. Dentist									
3. Pharmacist				5,520		48			
4. Podiatrist									
5. Physical Therapy									
a. Resident Care									
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)				36,000		184			
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)				576		6			
e. Other (Specify)									
9. Speech Therapist									
a. Resident Care									
b. Other									
10. Occupational Therapist									
a. Resident Care									
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care				127,068		1,588			
2. Administrative***				14,125		160			
b. LPN									
1. Direct Care				49,808		1,300			
2. Administrative***									
c. Aides				184,871		3,697			
d. Other									
12. Other (Specify) See Attached Schedule									
<b>B-13 Total Fees Paid in Lieu of Salaries</b>				424,441		7,091	6,292		105

\* 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.

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

Name of Facility Leeway, Inc.		License No. 2167-C		Report for Year Ended 9/30/2023	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Guardian Consulting Services	Dietician	<input type="radio"/>	<input checked="" type="radio"/>			
Anunuddha Walallyadda, MD	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
Yale University School of Medicine	Staff Development training	<input type="radio"/>	<input checked="" type="radio"/>			
Lisa Meadows	MDS Coordinator	<input type="radio"/>	<input checked="" type="radio"/>			
Clipboard Health	RN, LPN, C.N.A staffing	<input type="radio"/>	<input checked="" type="radio"/>			
Everthing Staffing	C.N.A. Staffing	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
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		<input type="radio"/>	<input checked="" type="radio"/>			
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		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			

\* 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 Year Ended					Page	of
Leeway, Inc.	2167-C	9/30/2023					15	37
Item	Total	CCNH / RHNS	Adjustment	NurseFac-Aids	Adjustment	Residential Care Home	Adjustment	
<b>1. Administrative and General</b>								
<b>a. Employee Health &amp; Welfare Benefits</b>								
1. Workmen's Compensation	\$ 176,225			137,144		39,081		
2. Disability Insurance	\$							
3. Unemployment Insurance	\$ 6,783			5,279		1,504		
4. Social Security (F.I.C.A.)	\$ 237,592			184,902		52,690		
5. Health Insurance	\$ 236,359			183,942		52,417		
6. Life Insurance (employees only) (not-owners and not-operators)	\$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 104,366			81,221		23,145		
8. Uniform Allowance	\$ 2,691			2,094		597		
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 359			280		79		
<b>b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*</b>	\$							
<b>c. Bad Debts*</b>	\$			79,733	(79,733)	25,061	(25,061)	
<b>d. Accounting and Auditing</b>	\$ 25,004			18,860		6,144		
<b>e. Legal (<i>Services should be fully described on Page 15b</i>)</b>	\$ 3,000			2,263		737		
<b>f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*</b>	\$							
<b>g. Office Supplies</b>	\$ 11,922			8,992		2,930		
<b>h. Telephone and Cellular Phones</b>								
1. Telephone & Pagers	\$ 30,334			24,941		8,126	(2,733)	
2. Cellular Phones	\$ 3,927			3,459	(659)	1,127		
<b>i. Appraisal (<i>Specify purpose and attach copy</i>)*</b>	\$							
<b>j. Corporation Business Taxes (<i>franchise tax</i>)</b>	\$							
<b>k. Other Taxes (<i>Not related to property - See Page 22</i>)</b>								
1. Income*	\$							
2. Other ( <i>Specify</i> ) See Attached Schedule	\$							
3. Resident Day User Fee	\$ 198,181			198,181				
<b>Subtotal</b>	\$ 1,036,743			931,291	(80,392)	213,638	(27,794)	

\* 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	NurseFac-Aids	Adjustment	Residential Care Home	Adjustment
Employee Assistance Program			\$ 280		\$ 79	
<b>Total</b>	\$ -	\$ -	\$ 280	\$ -	\$ 79	\$ -

**Schedule of Other Taxes**

Description	CCNH / RHNS	Adjustment	NurseFac-Aids	Adjustment	Residential Care Home	Adjustment
<b>Total</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

## General Information and Questionnaire Accounting Basis

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2023	Page 15b	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:  
 Accrual     Cash     Modified Cash

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

**Independent Accounting Firm**

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

**Services Provided by This Firm (describe fully)**

1 Audit and Form 990. Consolidation cost split between entities.	\$	25,004
2	\$	
3	\$	
4	\$	
		<b>Charge for Services Provided</b>
		\$ 25,004

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

**Legal Services Information**

Name of Legal Firm or Independent Attorney 1 Greentree Risk Management 2 3 4 5	Telephone Number
---	------------------

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

**Services Provided by This Firm (describe fully)**

1 Legal Advisory service related to Labor Relations	\$	3,000
2	\$	
3	\$	
4	\$	
5	\$	
		<b>Charge for Services Provided</b>
		\$ 3,000

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

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

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2023				Page 16	of 37
Item	Total	CCNH / RHNS	Adjustment	NurseFac- Aids	Adjustment	Residential Care Home	Adjustment
<b>Subtotals Brought Forward:</b>	1,036,743			931,291	(80,392)	213,638	(27,794)
<b>1. Travel and Entertainment</b>							
1. Resident Travel and Entertainment \$							
2. Holiday Parties for Staff \$	475			358		117	
3. Gifts to Staff and Residents \$	9,348			7,051		2,297	
4. Employee Travel \$	1,693			1,277		416	
5. Education Expenses Related to Seminars and Conventions \$	7,003			5,283		1,720	
6. Automobile Expense ( <i>not purchase or depreciation</i> ) \$	6,938			5,233		1,705	
7. Other ( <i>Specify</i> ) See Attached Schedule \$							
<b>m. Other Administrative and General Expenses</b>							
1. Advertising Help Wanted ( <i>all such expenses</i> ) \$	9,731			7,340		2,391	
2. Advertising Telephone Directory ( <i>all such expenses</i> )*** \$							
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule \$							
4. Fund-Raising*** \$				2,907	(2,907)	947	(947)
5. Medical Records \$							
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)*** \$							
7. Postage \$	4,181			3,154		1,027	
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule \$	10,650			8,033		2,617	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.*** \$				425	(425)	138	(138)
9. Subscriptions \$	1,770			1,335		435	
10. Contributions*** See Attached Schedule \$							
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> ) \$	128,140			98,954		29,186	
12. Administrative Management Services** \$							
13. Other ( <i>Specify</i> ) See Attached Schedule \$	147,576			132,413	(20,194)	49,134	(13,777)
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 1,364,248			1,205,054	(103,918)	305,768	(42,656)

\* 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 in the Adjustment column.



## Schedule of Other Travel and Entertainment

Description	CCNH / RHNS	Adjustment	NurseFac-Aids	Adjustment	Residential Care Home	Adjustment
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

## Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	NurseFac-Aids	Adjustment	Residential Care Home	Adjustment
<b>Total Other Advertising</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

## Schedule of Dues

Description	CCNH / RHNS	Adjustment	NurseFac-Aids	Adjustment	Residential Care Home	Adjustment
Leading Age			\$ 5,627		\$ 1,833	
ALTCFM			\$ 136		\$ 44	
CARCH			\$ 528		\$ 172	
Vendomate			\$ 207		\$ 68	
SHRM			\$ 184		\$ 60	
Ct. Colition to end Homeless			\$ 386		\$ 126	
CAHCF			\$ 901		\$ 293	
BJ			\$ 64		\$ 21	
<b>Total Dues</b>	\$ -	\$ -	\$ 8,033	\$ -	\$ 2,617	\$ -

## Schedule of Contributions

Description	CCNH / RHNS	Adjustment	NurseFac-Aids	Adjustment	Residential Care Home	Adjustment
<b>Total Contributions</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

## Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	NurseFac-Aids	Adjustment	Residential Care Home	Adjustment
New Hire - Dietary			\$ 2,115		\$ 689	
New Employee Hire			\$ 69,933		\$ 22,782	
Agency Hire Fees			\$ 2,995		\$ 976	
Licenses & Fees			\$ 1,972		\$ 642	
Bank Charges			\$ 5,558		\$ 1,811	
Employee Service Awards			\$ 211		\$ 69	
Health & Drug Screening			\$ 12,410		\$ 4,043	
Employee Background Checks			\$ 5,035		\$ 1,640	
Nursing Home Week Celebration			\$ 2,101		\$ 684	
Office Supplies - Dietary			\$ 565		\$ 184	
Computer Supplies & Minor Equ			\$ 1,764		\$ 575	
Board of Directors Expense			\$ 123		\$ 40	
Cable TV			\$ 8,893	\$ (1,694)	\$ 8,894	\$ (7,750)
Penalties And Late Fees			\$ 238		\$ 78	
Lobbying Expenses			\$ 9,994	\$ (9,994)	\$ 3,256	\$ (3,256)
Barber & Beauty			\$ 236	\$ (236)	\$ 77	\$ (77)
Credit Card Fees			\$ 609	\$ (609)	\$ 199	\$ (199)
Resident Personal Items			\$ 714	\$ (714)	\$ 232	\$ (232)
POD / Patient Training			\$ (511)	\$ 511	\$ (167)	\$ 167
Non-Reimbursable			\$ 7,458	\$ (7,458)	\$ 2,430	\$ (2,430)
<b>Total Other Administrative and General</b>	\$ -	\$ -	\$ 132,413	\$ (20,194)	\$ 49,134	\$ (13,777)

**Schedule C-1 - Management Services\***

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2023	Page of 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 #

\* 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.

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

Name of Facility		License No.	Report for Year Ended				Page	of
Leeway, Inc.		2167-C	9/30/2023				18	37
Item	Total	CCNH / RHNS	Adjustment	NurseFac-Aids	Adjustment	Residential Care Home	Adjustment	
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	\$ 236,242			121,147	(1,355)	117,767	(1,317)	
2. Non-Food Supplies	\$ 35,006			17,751		17,255		
3. Other (Specify) _____	\$							
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 576,141			292,147		283,994		
c. Other (Specify) _____ Dietary Uniforms	\$ 380			193		187		
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 847,769</b>			<b>431,238</b>	<b>(1,355)</b>	<b>419,203</b>	<b>(1,317)</b>	
2E. Dietary Questionnaire		Total	CCNH / RHNS	NurseFac-Aids	Residential Care Home			
F. Resident Meals: Total no. of meals served per day:*	126,348	63,174	32,034	31,140				
G. Is cost of employee meals included in 2D?	<input checked="" type="radio"/> Yes <input type="radio"/> No							
H. Did you receive revenue from employees?	<input checked="" type="radio"/> Yes <input type="radio"/> No		If yes, specify amt.		2672			
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)					30			
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.					
K. Is any revenue collected from these people?	<input type="radio"/> Yes <input checked="" type="radio"/> 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?	<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.					
N. Is any revenue collected from employees?	<input type="radio"/> Yes <input checked="" type="radio"/> 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.

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

Name of Facility Leeway, Inc.		License No. 2167-C	Report for Year Ended 9/30/2023				Page 19	of 37
Item		Total	CCNH / RHNS	Adjustment	NurseFac- Aids	Adjustment	Residential Care Home	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. \$	33,920		30,400		3,520	
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. \$	2,259		2,063		196	
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)		\$						
<b>3D. Total Laundry Expenditures (3a + b + c)</b>		\$	36,179		32,463		3,716	
3E. Laundry Questionnaire								
F. Is cost of employee laundry included in 3D?		<input type="radio"/> Yes		<input checked="" type="radio"/> No		If yes, specify cost.		
G. Did you receive revenue from employees?		<input type="radio"/> Yes		<input checked="" type="radio"/> 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?		<input type="radio"/> Yes		<input checked="" type="radio"/> No		If yes, specify cost.		
J. Did you receive revenue from these people?		<input type="radio"/> Yes		<input checked="" type="radio"/> 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.

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

Name of Facility		License No.	Report for Year Ended				Page	of
Leeway, Inc.		2167-C	9/30/2023				20	37
Item		Total	CCNH / RHNS	Adjustment	NurseFac-Aids	Adjustment	Residential Care Home	Adjustment
4.	Housekeeping							
a.	In-House Care							
	1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	\$ 33,855			29,375		4,480	
	Sq. Ft. Serviced by Personnel							
	Amt.	\$						
b.	Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )	\$ 233,590			174,964		58,626	
	Sq. Ft. Serviced by Personnel							
	Amt.	\$						
	C. Other ( <i>Specify</i> )	\$ 10,292			5,852		4,440	
	Minor Furnishings & Equip							
4D.	<b>Total Housekeeping Expenditures</b> (4a + b + c)	\$ 277,737			210,191		67,546	
5.	Resident Care (Supplies)**							
a.	Prescription Drugs***							
	1. Own Pharmacy	\$						
	2. Purchased from	\$			180,915	(180,915)		
	b. Medicine Cabinet Drugs	\$ 31,389			31,389			
	c. Medical and Therapeutic Supplies	\$ 120,082			120,082			
	d. Ambulance/Limousine***	\$ 11			62	(51)		
	e. Oxygen							
	1. For Emergency Use	\$						
	2. Other***	\$ 4,088			4,088			
	f. X-rays and Related Radiological Procedures***	\$ 423			3,448	(3,025)		
	g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$						
	h. Laboratory***	\$ 2,355			7,898	(5,543)		
	i. Recreation	\$ 2,070			2,302	(750)	768	(250)
	j. Direct Management Services*	\$						
	k. Indirect Management Services*	\$						
	l. Cable TV	\$						
	m. Other (Specify)**** See Attached Schedule	\$ 22,066			19,380	(768)	3,454	
	n. Physical Therapy Expense	\$						
	o. Speech Therapy Expense	\$						
5P.	<b>Total Resident Care Expenditures</b> (5a - 5o)	\$ 182,484			369,564	(191,052)	4,222	(250)

\* 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	NurseFac-Aids	Adjustment	Residential Care Home	Adjustment
Medical Equip - Title 19			\$ 5,527			
Medical Equip - Med A			\$ 56	\$ (56)		
Medical Equip - T19			\$ 1,853			
IV - T-19			\$ 6,641			
Wound Vac - Medicare			\$ 712	\$ (712)		
Minor Equip & Furniture - Nursing			\$ 4,591			
RCH SUPPLIES					\$ 3,454	
<b>Total Other Resident Care</b>	\$ -	\$ -	\$ 19,380	\$ (768)	\$ 3,454	\$ -

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

Name of Facility Leeway, Inc.			License No. 2167-C		Report for Year Ended 9/30/2023				Page of 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	NurseFac-Aids	Residential Care Home	Pg	Line
Glendale		<input type="radio"/>	<input checked="" type="radio"/>		Dietary		292,147	283,994	18	
Unitex Laundry Services		<input type="radio"/>	<input checked="" type="radio"/>		Laundry		30,400	3,520	19	
Diversified Building Services		<input type="radio"/>	<input checked="" type="radio"/>		Housekeeping		174,964	58,626	20	
Controlled Air		<input type="radio"/>	<input checked="" type="radio"/>		HVAC		6,223	4,720	22	
John's Refuse		<input type="radio"/>	<input checked="" type="radio"/>		Trash		6,526	4,951	22	
Connecticut Business Systems		<input type="radio"/>	<input checked="" type="radio"/>		Office Equip Maint		16,628	5,417	22	
Point Click Care		<input type="radio"/>	<input checked="" type="radio"/>		Software		31,200	10,164	16	
AOS, Inc.		<input type="radio"/>	<input checked="" type="radio"/>		Computer Server Admin		30,505	9,938	16	
Paylocity		<input type="radio"/>	<input checked="" type="radio"/>		Payroll Processing		16,559	5,395	16	
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

\* 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 Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2023					Page 22	of 37
Item	Total	CCNH / RHNS	Adjustment	NurseFac- Aids	Adjustment	Residential Care Home	Adjustment	
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	\$ 13,624			7,747		5,877		
b. Heat	\$ 30,784			17,505		13,279		
c. Light & Power	\$ 137,679			78,289		59,390		
d. Water	\$ 21,174			12,040		9,134		
e. Equipment Lease (Provide detail on page 22b)	\$ 625			355		270		
f. Other (itemize)	\$ 97,059			59,936		37,123		
See Attached Schedule								
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	\$ 300,945			175,872		125,073		
7. Depreciation (complete schedule page 23*)								
a. Land Improvements	\$ 19,627			11,161		8,466		
b. Building & Building Improvements	\$ 275,914			156,895		119,019		
c. Non-Movable Equipment	\$ 18,777			10,677		8,100		
d. Movable Equipment	\$ 65,116			37,028		28,088		
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	\$ 379,434			215,761		163,673		
8. Amortization (Complete att. Schedule Page 24*)								
a. Organization Expense	\$							
b. Mortgage Expense	\$ 7,284			4,142		3,142		
c. Leasehold Improvements	\$							
d. Other (Specify)	\$							
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	\$ 7,284			4,142		3,142		
9. Rental payments on leased real property less real estate taxes included in item 10b	\$							
10. Property Taxes								
a. Real estate taxes paid by owner	\$							
b. Real estate taxes paid by lessor	\$							
c. Personal property taxes	\$ 25			14		11		
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	\$ 386,743			219,917		166,826		

\* 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		NurseFac-Aids		Residential Care Home	
		Adjustment		Adjustment		Adjustment
Purchased Service - Plumber			\$ 272		\$ 207	
Purch Service - HVAC			\$ 6,223		\$ 4,720	
Purchased Services - Electric			\$ 563		\$ 427	
Purch Serv - Exterminator			\$ 1,432		\$ 1,087	
Purchased Serv - Alarm Service			\$ 769		\$ 583	
Purch Service - Fire Protecti			\$ 1,884		\$ 1,429	
Purch Serv - Sec camera Main			\$ 2,233		\$ 1,694	
Purch Service - Ridgefield As			\$ 4,777		\$ 3,623	
Purch Service - Elevator			\$ 4,425		\$ 3,356	
Purch Service - Telephone Rep			\$ 2,225		\$ 1,687	
Purch Serv - Nurse Call System			\$ 1,218		\$ 924	
Purchased Service - Shredding			\$ 570		\$ -	
Purchased Service - Generator			\$ 1,214		\$ 921	
Purch Serv - Snow Removal			\$ 313		\$ 237	
Purch Service - Med Equip Ins			\$ 1,058		\$ 802	
Purch Services - Legionella Rist Ass			\$ 1,987		\$ 1,507	
Trash Removal- Maint			\$ 6,526		\$ 4,951	
Medical Waste Removal			\$ 937		\$ -	
Landscaping			\$ 4,682		\$ 3,551	
Office Equip Maint Agreements			\$ 16,628		\$ 5,417	
<b>Total Other Repairs and Maintenance</b>	\$ -	\$ -	\$ 59,936	\$ -	\$ 37,123	\$ -

## General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility			License No.	Report for Year Ended			Page	of
Leeway, Inc.			2167-C	9/30/2023			22b	37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
Pitney Bowes	<input type="radio"/>	<input checked="" type="radio"/>	Postage Meter			625	625	
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
<b>Total ***</b>							625	

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes       No

\* 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.

### Depreciation Schedule

Name of Facility Leeway, Inc.			License No. 2167-C		Report for Year Ended 9/30/2023			Page 23	of 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			
<b>A. Land Improvements</b>													
1. Acquired prior to this report period			305,769		305,769	149,730	SL	Var	19,304				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			9,688						323				
A-4. Subtotal										19,627			
<b>B. Building and Building Improvements</b>													
1. Acquired prior to this report period			8,110,248		8,110,248	4,664,216	SL	Var	275,914				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal										275,914			
<b>C. Non-Movable Equipment</b>													
1. Acquired prior to this report period			362,796		362,796	219,260	SL	Var	18,731				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			1,379						46				
C-4. Subtotal										18,777			
		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								
<b>D. Movable Equipment</b>													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a.			X		4	2007	14,983	14,983	14,983	SL	5		
b.			X		8	2017	68,717	68,717	68,717	SL	6		
c.				X	7	2022	6,500	6,500	650	SL	5	1,301	
d.													
2. Movable Equipment													
a. Acquired prior to this report period							885,651	885,651	574,148	SL	Var	58,468	
b. Disposals (attach schedule)													
Acquired during this report period (attach schedule):													
c. Administrative							28,773					3,680	
d. Standard Resident							38,725					1,667	
e. Specialized Resident													
Total Acquired during this report period							67,498					5,347	
D-3. Subtotal													65,116
<b>E. Total Depreciation</b>													379,434

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
6/15/2023	Parking Apron in Front - All Around Home Improvements	\$ 9,688	15	\$ 323
<b>Total additions for Land Improvements</b>		\$ 9,688		\$ 323 *
<b>Deletions:</b>				
<b>Total deletions for Land Improvements</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
<b>Total additions for Building Improvements</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
12/12/2022	Coastline Mech Serv - Hot Water Heater Install	\$ 1,379	15	\$ 46
<b>Total additions for Non-Movable Equipment</b>		\$ 1,379		\$ 46 *
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ - **

\*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	Cost	Useful Life	Depreciation
		Movable Category			
<b>Additions:</b>					
10/12/2022	McKesson - Mattress	Standard Resident	\$ 1,213	10	\$ 60
10/19/2022	McKesson -	Standard Resident	\$ 1,060	10	\$ 53
11/2/2022	Unique Medical Supply -	Standard Resident	\$ 1,756	10	\$ 88
11/2/2022	Rehab Mart -	Standard Resident	\$ 407	10	\$ 20
11/14/2022	Unique Medical Supply -	Standard Resident	\$ 136	10	\$ 7
11/25/2022	LYMLLC - Karaoke DJ Laptop	Administrative	\$ 2,590	5	\$ 259
12/5/2022	United Office Furniture - HR/Finance	Administrative	\$ 2,722	15	\$ 90
1/26/2023	We IP Cam - New Security Camera	Administrative	\$ 2,718	10	\$ 136
2/3/2023	McKesson - Beds / Mattresses	Standard Resident	\$ 16,098	15	\$ 536
2/3/2023	Mace Company - NVR Camera	Administrative	\$ 2,255	10	\$ 113
2/21/2023	Advanced Office Systems - Dell Server	Administrative	\$ 11,104	3	\$ 1,851
2/28/2023	Advanced Office Systems - Server	Administrative	\$ 5,500	3	\$ 917
3/21/2023	Advanced Office Systems -	Administrative	\$ 1,224	3	\$ 204
2/21/2023	McKesson -	Standard Resident	\$ 1,538	10	\$ 77
4/28/2023	Advanced Office Systems - Additional Server Equip	Administrative	\$ 660	3	\$ 110
6/7/2023	ARJOHUNTLEIGH, INC - Hoyer Sling	Standard Resident	\$ 2,643	10	\$ 132
6/29/2023	McKesson -	Standard Resident	\$ 11,027	10	\$ 551
8/11/2023	McKesson -	Standard Resident	\$ 1,734	10	\$ 87
9/2/2023	McKesson - Air Mattress	Standard Resident	\$ 1,113	10	\$ 56
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
<b>Total additions for Movable Equipment</b>			\$ 67,498		\$ 5,347 *
<b>Deletions:</b>					
<b>Total deletions for Movable Equipment</b>			\$ -		\$ - **

\*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
<b>Additions:</b>				
<b>Total additions for Leasehold Improvement</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Amortization Schedule\***

Name of Facility Leeway, Inc.			License No. 2167-C		Report for Year Ended 9/30/2023			Page 24	of 37
Item	Date of Acquisition		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
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1. Key Bank Terminated 8/31/23 Net F	12	2014	15	20,361	15,773	S/L		1,866	
2. Key Bank Terminated 8/31/23 Net F	12	2014	20	59,107	39,899	S/L		5,418	
3. Webster Bank	8	2023	10	51,565		S/L			
B-4. Subtotal									7,284
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
<b>D. Total Amortization</b>									7,284

\* 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.

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

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2023	Page 25	of 37	
<b>11. Property Questionnaire</b>					
<b>Part A</b>					
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> 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 <b>NOT</b> Original Owner, Date of Purchase					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity					
6. Square Footage					
7. Acquisition Cost					
a. Land					
b. Building					
<b>Part B - Owner and Related Parties</b>		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)					
b. Date Mortgage Obtained					
c. Interest Rate for the Cost Year					
d. Term of Mortgage (number of years)					
e. Amount of Principal Borrowed					
f. Principal balance outstanding as of _____					
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>					
g. Type of Financing (e.g., fixed, variable)					
h. Date of Refinancing		08/28/23			
i. New Interest Rate					
j. Term of Mortgage (number of years)		10			
k. Amount of Principal Borrowed		2,250,000			
l. Principal Outstanding on Note Paid-Off		2,226,617			
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>					
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.

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

Name of Facility Leeway, Inc.		License No. 2167-C	Report for Year Ended 9/30/2023				Page 26	of 37
Item		Total	CCNH / RHNS	Adjustment	NurseFac- Aids	Adjustment	Residential Care Home	Adjustment
12. Interest								
A. Building, Land Improvement & Non-Movable Equipment								
1. First Mortgage		\$ 10636			6,048		4,588	
Name of Lender Key Bank - Terminated 8/31								
Rate Variable								
Address of Lender								
2. Second Mortgage		\$ 112,528			63,988		48,540	
Name of Lender Key Bank - Terminated 8/31								
Rate 5.00%								
Address of Lender								
3. Third Mortgage		\$ 12,884			7,326		5,558	
Name of Lender Webster Bank - Refinanced Key Bank								
Rate Variable								
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. <b>Total Building Interest Expense</b> (A1 - A4 + B5)		\$ 136,048			77,362		58,686	

(Carry Subtotals forward to next page)



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

Name of Facility	License No.	Report for Year Ended					Page	of
Leeway, Inc.	2167-C	9/30/2023					27	37
Item	Total	CCNH / RHNS	Adjustment	NurseFac-Aids	Adjustment	Residential Care Home	Adjustment	
Subtotals Brought Forward:	136,048			77,362		58,686		
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) Working Capital	\$	5,250		2,985		2,265		
13. Total All Interest Expense (12B7 + 12C3 + 12D)	\$	141,298		80,347		60,951		
14. Insurance								
a. Insurance on Property (buildings only)	\$	17,696		8,973		8,723		
b. Insurance on Automobiles	\$	10,699		5,425		5,274		
c. Insurance other than Property (as specified above)								
1. Umbrella (Blanket Coverage)	\$	38,528		29,984		8,544		
2. Fire and Extended Coverage	\$							
3. Other (Specify) Fid. Bond, Cyber, D&O, Crime	\$	32,552		25,333		7,219		
14d. Total Insurance Expenditures (14a + b + c)	\$	99,475		69,715		29,760		
15. Total All Expenditures (A-13 thru C-14)	\$	7,207,105		5,693,129	(336,352)	1,894,551	(44,223)	

**F. Statement of Revenue**

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2023			Page 30	of 37
Item	Total	CCNH / RHNS	NurseFac- Aids	Residential Care Home		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 6,496,775		4,722,734	1,774,041		
b. Medicaid Room and Board Contractual Allowance **	\$ (313,798)		(265,992)	(47,806)		
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 610,907		610,907			
b. Medicare Room and Board Contractual Allowance **	\$ 515,574		515,574			
4. a. Private-Pay Residents and Other	\$ 47,482			47,482		
b. Private-Pay Room and Board Contractual Allowance **	\$					
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 184,367		184,367			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (184,367)		(184,367)			
c. Prescription Drugs - Non-Medicare	\$					
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
2. a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$ 122,591		122,591			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (86,933)		(86,933)			
c. Physical Therapy - Non-Medicare	\$ 50,484		50,484			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (50,912)		(50,912)			
4. a. Speech Therapy - Medicare	\$ 9,824		9,824			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (7,690)		(7,690)			
c. Speech Therapy - Non-Medicare	\$ 6,539		6,539			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (6,988)		(6,988)			
5. a. Occupational Therapy - Medicare	\$ 84,289		84,289			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (61,281)		(61,281)			
c. Occupational Therapy - Non-Medicare	\$ 24,531		24,531			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (24,531)		(24,531)			
6. a. Other ( <i>Specify</i> ) - Medicare	\$					
b. Other ( <i>Specify</i> ) - Non-Medicare	\$					
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 7,416,863		5,643,146	1,773,717		
<b>IV. Other Revenue*</b>						
1. Meals sold to guests, employees & others	\$ 2,672		1,355	1,317		
2. Rental of rooms to non-residents	\$					
3. Telephone	\$ 2,733			2,733		
4. Rental of Television and Cable Services	\$ 7,750			7,750		
5. Interest Income ( <i>Specify</i> )	\$ 26,768		13,573	13,195		
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$ 35,252		24,319	10,933		
<b>V. Total Other Revenue</b> (I thru 8)	\$ 75,175		39,247	35,928		
<b>VI. Total All Revenue</b> (III +V)	\$ 7,492,038		5,682,393	1,809,645		

\* 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	NurseFac- Aids	Residential Care Home
30	Radiology-Medicare		\$ 1,182	
30	Radiology Revenue Medicare Replacement		\$ 1,982	
30	Lab- Medicare		\$ 1,550	
30	Lab Revenue Medicare Replacement		\$ 585	
	Contractual Allowance		\$ (5,299)	
<b>Total Other Resident Revenue - Medicare</b>		\$ -	\$ -	\$ -

**Schedule of Other Non-Medicare Resident Revenue**

**Related Exp**

Page Ref	Description	CCNH / RHNS	NurseFac- Aids	Residential Care Home
<b>Total Other Resident Revenue</b>		\$ -	\$ -	\$ -

**Interest Income**

**Account**

Page Ref	Account	Balance	CCNH / RHNS	NurseFac- Aids	Residential Care Home
	Money Market Account	Var		\$ 13,573	\$ 13,195
<b>Total Interest Income</b>			\$ -	\$ 13,573	\$ 13,195

**Schedule of Other Revenue**

Page Ref	Description	CCNH / RHNS	NurseFac- Aids	Residential Care Home
30	Misc. Revenue		\$ 1,980	\$ 645
30	Restricted Donations - Rec De		\$ 750	\$ 250
30	Fund Raiser-Annual Appeal		\$ 3,943	\$ 3,832
30	Donations - Unrestricted		\$ 17,139	\$ 5,713
30	Donations - United Way		\$ 507	\$ 493
<b>Total Other Revenue</b>		\$ -	\$ 24,319	\$ 10,933

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2023	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	1,707,083
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	732,700
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	178,366
4. Inventories			\$	
5. Prepaid Expenses			\$	15,489
a. _____				
b. _____				
c. _____				
d. See Schedule		15,489		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	
_____				
_____				
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	2,633,638
B. Fixed Assets				
1. Land			\$	581,784
2. Land Improvements	*Historical Cost	315,457	\$	146,100
	Accum. Depreciation	169,357	Net	
3. Buildings	*Historical Cost	8,110,248	\$	3,170,118
	Accum. Depreciation	4,940,130	Net	
4. Leasehold Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____	Net	
5. Non-Movable Equipment	*Historical Cost	372,499	\$	134,462
	Accum. Depreciation	238,037	Net	
6. Movable Equipment	*Historical Cost	953,152	\$	315,189
	Accum. Depreciation	637,963	Net	
7. Motor Vehicles	*Historical Cost	90,200	\$	4,549
	Accum. Depreciation	85,651	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	1,964,495
_____				
See Schedule		1,964,495		
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	6,316,697

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

(Carry Total forward to next page)

## Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
		Prepaid Insurance	\$ 1,333
		Prepaid Dues	\$ 1,753
		Prepaid IT Support	\$ 4,743
		Prepaid Maintenance	\$ 2,851
		Prepaid Fire Alarm Service	\$ 1,293
		Prepaid Relias	\$ 3,516
<b>Total Prepaid Expenses</b>			<b>\$ 15,489</b>

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

Page Ref	Line Ref	Description	
<b>Total Other Current Assets (Itemize)</b>			<b>\$ -</b>

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

Page Ref	Line Ref	Description	
		Assets (Net of Accum Depreciation) - Non-Reimbursable	\$ 1,963,035
		CIP - Elevator	\$ 1,460
<b>Total Other Other Fixed Assets (Itemize)</b>			<b>\$ 1,964,495</b>

## Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Board Designated Fund	\$ 181,041
		Deferred Financing - Webster	\$ 51,565
<b>Total Other Assets</b>			<b>\$ 232,606</b>

## Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
		Tractor & Snowblower	\$ 17,660
<b>Total Notes Payable</b>			<b>\$ 17,660</b>

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

Page Ref	Line Ref	Description	
		Resident Trust	\$ 29,828
		Accrued Provider Tax	\$ 51,730
		Deferred Income DOH	\$ 11,703
		Deferred Income HOPWA	\$ 40
		Deferred Income DMHAS	\$ (1,367)
		Deferred Income DSS Case Mgmt	\$ 255,781
		DSS Medicaid Reserve	\$ 532,719
<b>Total Other Current Liabilities (Itemize)</b>			<b>\$ 880,434</b>

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

Page Ref	Line Ref	Description	
		DSS Bond Advance	\$ 675,000
		Mortgage Swap Liability	\$ 10,539
<b>Total Other Current Liabilities (Itemize)</b>			<b>\$ 685,539</b>

### G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2023	32	37
Account			Amount	
Total Brought Forward:			\$	8,950,335
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			\$	
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$	
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 ( <i>itemize</i> )			\$	
_____				
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	
Name and Address	Amount	Loan Date		
7. Other Assets ( <i>itemize</i> )			\$	232,606
_____				
See Schedule				
				232,606
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$	232,606
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$	9,182,941

\* 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 Leeway, Inc.		License No. 2167-C	Report for Year Ended 9/30/2023	Page 33	of 37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	562,562
2. Notes Payable ( <i>itemize</i> )				\$	17,660
_____					
_____					
See Schedule					17,660
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$	105,148
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	4,618
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable ( <i>Current Portion</i> )				\$	
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities ( <i>itemize</i> )				\$	880,434
_____					
_____					
_____					
See Schedule					880,434
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>				\$	<b>1,570,422</b>

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

(Carry Total forward to next page)

### G. Balance Sheet (cont'd)

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2023		Page 34	of 37
Account				Amount	
Total Brought Forward:				1,570,422	
<b>Liabilities (cont'd)</b>					
B. Long-Term Liabilities					
1. Loans Payable-Equipment ( <i>itemize</i> )					
\$					
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable				\$ 2,250,033	
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$	
Name and Address of Lender	Amount	Loan Date			
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$ 685,539	
See Schedule		685,539			
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 2,935,572	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 4,505,994	



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

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2023	35	37
Account			Amount	
<b>A. Reserves</b>				
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>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	4,585,073
6. Gain or Loss for Period			\$	91,874
	10/1/2022	thru	9/30/2023	
7. Total Net Worth			\$	4,676,947
<b>C. Total Reserves and Net Worth</b>			\$	4,676,947
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	9,182,941

### H. Changes in Total Net Worth

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2023	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2022			\$	4,585,073
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	7,492,038
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	7,587,580
D. Net Income or Deficit			\$	(95,542)
E. Balance			\$	4,489,531
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
Grant, Housing & Non-Reimbursable Revenue	1,245,932			
Grant, Housing & Non-Reimbursable Expenses	(1,058,516)			
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	187,416
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>	Title	Amount		
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose	Amount			
3. Total Deductions			\$	
H. <b>Balance at End of Period</b>			\$	4,676,947
				09/30/23

### I. Preparer's/Reviewer's Certification

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2023	Page 37	of 37
<i>Check appropriate category</i>				
Chronic and Convalescent Nursing <input checked="" type="checkbox"/> Home (CCNH) & RHNS Combined	<input checked="" type="checkbox"/> NurseFac-Aids	<input checked="" type="checkbox"/> Residential Care Home		
<b>Preparer/Reviewer Certification</b>				
<p>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.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Robert Morgan , CPA				
Address Address			Phone Number	
13872 Posada St., Venice Fl			941 303-3958	
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number	
Robert Ross			203 865-0068	
Contact Email Address				
rross@leeway.net				