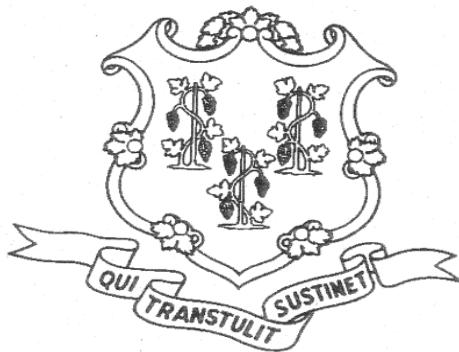


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2021

Name of Facility (as licensed) Leeway, Inc.	
Address (No. & Street, City, State, Zip Code) 40 Albert Street, New Haven, Ct. 06511	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input checked="" type="checkbox"/> Residential Care Home (RCH)
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

License Numbers:	CCNH 2167-C	RHNS	Residential Care Home 1891-RCH	Medicare Provider
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Medicaid Provider Numbers:	CCNH 42169	RHNS	ICF-IID
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For Department Use Only

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

General Information

Name of Facility (as licensed) Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2021	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, 2020 and ending September 30, 2021, 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:	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public			

(Notary Seal)

Table of Contents

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

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-1A Rev. 6/95

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Leeway, Inc.	Period Covered:		From 10/1/2020	To 9/30/2021
Address of Facility 40 Albert Street, New Haven, Ct. 06511				
Report Prepared By Robert Morgan, CPA	Phone Number 941 303-3958	Date 2/15/2022		
Item	Total	CCNH	RHNS	Residential Care Home
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

	Phone No. of Facility 203 865-0068	Report for Year Ended 9/30/2021	Page 2
Name of Facility (as shown on license) Leeway, Inc.		Address (No. & Street, City, State, Zip) 40 Albert Street, New Haven, Ct. 06511	
License Numbers:	CCNH 2167-C	RHNS	Residential Care Home 1891-RCH
Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input checked="" type="checkbox"/> Residential Care Home			
Type of Ownership (Check appropriate box)		<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input checked="" type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> 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.
Administrator			
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 Partners/Members

General Information and Questionnaire
Corporate Owners

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2021	Page of 3A 37
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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 William Dyson, Chairman	Business Address	Title	No. Shares Held by Each
Patricia Comer, 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

Individual Proprietorship

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2021	Page 3B	of 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

General Information and Questionnaire

Related Parties*

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2021			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input checked="" type="radio"/> Yes <input type="radio"/> 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?				<input checked="" type="radio"/> Yes <input type="radio"/> 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 & other reimbursement	10,A.4	27,525	27,525
Leeway-Putnam Housing Corp.		<input type="radio"/>	<input checked="" type="radio"/>		Rental of DMHSA Funded Office Space			
Leeway - Wilton Housing Corp		<input type="radio"/>	<input checked="" type="radio"/>		Rental of DMHSA Funded Office Space			
Leeway Scattered Site Housing Corp		<input type="radio"/>	<input checked="" type="radio"/>		None			
Michael Dunn, Esq., Greentree Risk Management		<input checked="" type="radio"/>	<input type="radio"/>	98%	Labor Relations Legal Risk Management	15, 1.e	3,000	3,000
		<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 9/30/2021	Page 5	of 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 (<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.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-6 Rev. 9/2002

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

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

Name of Facility		License No.		Report for Year Ended			Page	of
Leeway, Inc.		2167-C		9/30/2021			6	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		with auto renewal	821		821
	<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"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?				<input type="radio"/>	Yes	<input checked="" type="radio"/>	No	Total ***
								821

* 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.

General Information and Questionnaire

Accounting Basis

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2021	Page 7	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 Yes If "No," explain.
previous period? No

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

1 Audited Financial Statements, Single Audit, and Form 990	\$ 27,996
2 Note: Costs associated with Consolidation are paid proportionately by each entity.	\$
3	\$
4	\$
	Charge for Services Provided \$ 27,996

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

Yes No 15

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)

1 2 3 4 5	
-----------------------	--

Services Provided by This Firm (*describe fully*)

1 Legal Labor Risk Management	\$ 3,000
2 Legal disllwed Page 28	\$ 158
3	\$
4	\$
5	\$
	Charge for Services Provided \$ 3,158

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

Yes No 15

Schedule of Resident Statistics

Name of Facility Leeway, Inc.			License No. 2167-C				Report for Year Ended 9/30/2021				Page 8	of 37
	Total All Levels	Total CCNH Level	Total RHNS Level	Total Residential Care Home	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Residential Care Home	Total	CCNH	RHNS	Residential Care Home
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	60	30		30	60	30		30				
B. On last day of THIS report period	60	30		30					60	30		30
2. Number of Residents												
A. As of midnight of PREVIOUS report period	59	29		30	59	29		30				
B. As of midnight of THIS report period	58	29		29					58	29		29
3. Total Number of Days Care Provided During Period												
A. Medicare	1,122	1,122			901	901			221	221		
B. Medicaid (Conn.)	9,410	9,410			7,004	7,004			2,406	2,406		
C. Medicaid (other states)												
D. Private Pay	365			365	273			273	92			92
E. State SSI for RCH	10,376			10,376	7,836			7,836	2,540			2,540
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	21,273	10,532		10,741	16,014	7,905		8,109	5,259	2,627		2,632
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	21,273	10,532		10,741	16,014	7,905		8,109	5,259	2,627		2,632

Schedule of Resident Statistics (Cont'd)

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2021	Page 9	of 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	Residential Care Home	Lost			Gained			CCNH	RHNS	Residential Care Home		
				(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	Residential Care Home
1st change				
2nd change				
3rd change				
4th change				

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	Residential Care Home	R.C.H.	ICF-MR
No. of Residents	1	28					1	28
Per Diem Rate								
a. One bed rm.	Various	496.50		450.00		170.00	158.49	
b. Two bed rms.								
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B	406	406	Residential Care Home
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments	404	404	
C. Other	629	629	
D. Total Physical Therapy Treatments	1,439	1,439	

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	189	189	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments	364	364	
C. Other	254	254	
D. Total Speech Therapy Treatments	807	807	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	294	294	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments	262	262	
C. Other	493	493	
D. Total Occupational Therapy Treatments	1,049	1,049	

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		2167-C	9/30/2021	10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes <input type="radio"/> No			
Item	CCNH	Hours	RHNS	Hours	Residential Care Home Hours
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	125,191	1,403			40,784 457
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	100,697	3,929			19,302 602
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	63,824	1,144			48,417 868
b. Other Maintenance Workers	27,926	1,183			21,185 897
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers					
9. Barber and Beautician Services					
10. Protective Services	155,419	7,229			117,900 5,484
11. Accounting Services					
a. Head Accountant	102,813	1,414			33,494 460
b. Other Accountants	193,740	6,643			63,116 2,164
12. Professional Care of Residents					
a. Directors and Assistant Director of Nurses	146,794	2,171			
b. RN					
1. Direct Care	488,985	10,589			
2. Administrative**	129,821	2,948			
c. LPN					
1. Direct Care	165,287	3,964			
2. Administrative**					
d. Aides and Attendants	575,235	24,541			351,042 15,893
e. Physical Therapists	135,571	2,715			
f. Speech Therapists	30,639	560			
g. Occupational Therapists	42,270	819			
h. Recreation Workers	51,879	2,001			17,293 667
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	189,797	5,040			
n. Marketing					
o. Other (Specify)					
See Attached Schedule					
<i>A-13. Total Salary Expenditures</i>	2,725,888	78,293			712,533 27,492

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

** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and

Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

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

Schedule of Other Salaries and Wages (Page 10)

Schedule of Other Fees (Page 13)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-11 Rev. 10/2005

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

Name of Facility Leeway, Inc.			License No. 2167-C		Report for Year Ended 9/30/2021			Page 11	of 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							
Section I - Operators/Owners									
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).									

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

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

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-12 Rev. 10/2005

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

Name of Facility (as licensed) Leeway, Inc.			License No. 2167-C		Report for Year Ended 9/30/2021			Page 12	of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Residential Care Home							
Section III - Administrators***										
Jay Katz	125,191		40,784	Standard Employee	Responsible for total operations	1,860	A.2	Housing & Grant oversight	220	19,662
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.

B. Report of Expenditures - Professional Fees

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2021		Page 13	of 37
Item	Total Cost and Hours				
	CCNH	Hours	RHNS	Hours	Residential Care Home
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)					
1. Dietitian	1,011	24			1,032
2. Dentist					
3. Pharmacist	3,110	48			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	1,530	24			
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	36,000	196			
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**					
d. Administrative Services facility					
1. Infection Control Committee (Quarterly meetings)					
2. Pharmaceutical Committee (Quarterly meetings)					
3. Staff Development Committee (Once annually)	13,832	96			
e. Other (Specify)					
9. Speech Therapist					
a. Resident Care					
b. Other					
10. Occupational Therapist					
a. Resident Care	6,878	106			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	27,667	281			
2. Administrative***	10,800	108			
b. LPN					
1. Direct Care	4,932	136			
2. Administrative***					
c. Aides	14,235	540			
d. Other					
12. Other (Specify)					
See Attached Schedule					
B-13 Total Fees Paid in Lieu of Salaries	119,995	1,559			1,032
					24

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

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

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

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

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2021	Page 15	of 37
Item	Total	CCNH	RHNS	Residential Care Home
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 116,849	92,635		24,214
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 1,425	1,130		295
4. Social Security (F.I.C.A.)	\$ 254,162	201,493		52,669
5. Health Insurance	\$ 246,622	195,516		51,106
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 79,767	63,237		16,530
8. Uniform Allowance	\$ 2,395	1,899		496
9. Other (<i>Specify</i>) See Attached Schedule	\$ (8,294)	(6,575)		(1,719)
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 16,620	12,964		3,656
d. Accounting and Auditing	\$ 27,996	21,117		6,879
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 3,158	2,382		776
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 10,614	8,006		2,608
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 28,418	21,435		6,983
2. Cellular Phones	\$ 4,265	3,217		1,048
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$			
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$			
2. Other (<i>Specify</i>) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 210,000	210,000		
Subtotal	\$ 993,997	828,456		165,541

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

(Carry Subtotals forward to next page)

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

Attachment Page 15

Schedule of Other Employee Benefits

Schedule of Other Taxes

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

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

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2021		Page 16	of 37
Item		Total	CCNH	RHNS	Residential Care Home
	<i>Subtotals Brought Forward:</i>	993,997	828,456		165,541
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	6,604	4,981		1,623
3. Gifts to Staff and Residents	\$	6,648	5,014		1,634
4. Employee Travel	\$	1,154	870		284
5. Education Expenses Related to Seminars and Conventions	\$	6,608	4,984		1,624
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$	1,617	1,220		397
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	3,630	2,738		892
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$				
4. Fund-Raising***	\$	120,665	91,015		29,650
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$	8,503	6,414		2,089
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	10,073	7,596		2,477
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	1,238	934		304
9. Subscriptions	\$	873	658		215
10. Contributions*** See Attached Schedule	\$	500	248		252
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	233,036	176,142		56,894
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$	(42,235)	(36,933)		(5,302)
<i>C-14 Total Administrative & General Expenditures</i>	\$	1,352,911	1,094,337		258,574

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

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	Residential Care Home
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

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

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
Leading Age	\$ 5,923		\$ 1,930
ALTCFM	\$ 128		\$ 42
CARCH	\$ 528		\$ 172
Vendomate	\$ 109		\$ 36
Danosky & Associates	\$ 339		\$ 111
Ct Coalition Homeless	\$ 245		\$ 80
CAHCF	\$ 264		\$ 86
BJ	\$ 60		\$ 20
Total Dues	\$ 7,596	\$ -	\$ 2,477

Schedule of Contributions

Description	CCNH	RHNS	Residential Care Home
PBA	\$ 248		\$ 252
Total Contributions	\$ 248	\$ -	\$ 252

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
New Hire - Dietary	\$ 808		\$ 263
New Employee Hire	\$ 1,379		\$ 449
Licenses & Fees	\$ 1,542		\$ 503
Bank Charges	\$ 3,948		\$ 1,286
Employee Service Awards	\$ 356		\$ 116
Health & Drug Screening	\$ 2,673		\$ 871
Employee Background Checks	\$ 3,200		\$ 1,042
Nursing Home Week Celebration	\$ 1,775		\$ 578
Offifice Supplies - Dietary	\$ 546		\$ 178
Computer Supplies & Minor Equ	\$ 1,332		\$ 434
Cable TV - Allowable	\$ 1,800		\$ 1,800
Board of Directors Expense	\$ 122		\$ 40
Mgmt & Board Retreat	\$ 1,051		\$ 343
Self Disallowances:			
Cable TV	\$ 8,180	\$ -	\$ 8,181
Penalties And Late Fees	\$ 54	\$ -	\$ 17
Lobbying Expenses	\$ 10,748	\$ -	\$ 3,502
Barber & Beauty	\$ 492	\$ -	\$ 160
Credit Card Fees	\$ 2,197	\$ -	\$ 716
Resident Personal Items	\$ 280	\$ -	\$ 91
Swap Expense	\$ (79,416)	\$ -	\$ (25,872)
Total Other Administrative and General	\$ (36,933)	\$ -	\$ (5,302)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2021	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
	2167-C	9/30/2021		18 37
Item	Total	CCNH	RHNS	Residential Care Home
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 178,121	88,186		89,935
2. Non-Food Supplies	\$ 28,086	13,905		14,181
3. Other (Specify) _____	\$ _____			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 533,867	264,311		269,556
c. Other (Specify) _____	\$ _____			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 740,074	366,402		373,672
2E. Dietary Questionnaire	Total	CCNH	RHNS	Residential Care Home
F. Resident Meals: Total no. of meals served per day:*				
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.
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? <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 9/30/2021		Page 19 37
Item	Total	CCNH	RHNS	Residential Care Home
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. 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. \$	3,420	3,123	297
4. Repair and/or purchase of linens.***	Lbs.			
	Amt. \$			
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$	26,416	24,101	2,315
c. Other (Specify)	\$			
3D. Total Laundry Expenditures (3a + b + c)	\$	29,836	27,224	2,612
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 Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2021		Page 20	of 37
Item		Total	CCNH	RHNS	Residential Care Home
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 34,409	31,863		2,546
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)					
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel				
	Amt.	\$ 325,906	194,224		131,682
C. Other (<i>Specify</i>)	\$	5,069	2,882		2,187
Minor Furnishings					
4D. Total Housekeeping Expenditures (4a + b + c)	\$	365,384	228,969		136,415
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Procare LTC	\$	168,409	168,409		
b. Medicine Cabinet Drugs	\$	13,968	13,968		
c. Medical and Therapeutic Supplies	\$	115,950	115,950		
d. Ambulance/Limousine***	\$	2,529	2,529		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	6,126	6,126		
f. X-rays and Related Radiological Procedures***	\$	3,283	3,283		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$	840	840		
h. Laboratory***	\$	10,717	10,717		
i. Recreation	\$	3,102	2,326		776
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	33,228	30,136		3,092
5M. Total Resident Care Expenditures (5a - 5j)	\$	358,152	354,284		3,868

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

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

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

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

Schedule of Other Resident Care

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 9/30/2021				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	Residential Care Home	Pg	Line
Glendale		<input type="radio"/>	<input checked="" type="radio"/>		Dietary	263,653		268,886	18	
Unitex Laundry Services		<input type="radio"/>	<input checked="" type="radio"/>		Laundry	24,101		2,315	19	
Diversified Building Services		<input type="radio"/>	<input checked="" type="radio"/>		Housekeeping	194,224		131,682	20	
Controlled Air		<input type="radio"/>	<input checked="" type="radio"/>		HVAC	7,284		5,525	22	
All Around Home Improvements		<input type="radio"/>	<input checked="" type="radio"/>		Snow Removal	11,259		8,541	22	
John's Refuse & Recycling		<input type="radio"/>	<input checked="" type="radio"/>		Trash Removal	5,610		4,256	22	
Connecticut Business Systems		<input type="radio"/>	<input checked="" type="radio"/>		Office Equip Maintenance	12,011		3,913	22	
Point Click Care		<input type="radio"/>	<input checked="" type="radio"/>		Maintenance & License Fee	24,699		8,047	16	
EBM		<input type="radio"/>	<input checked="" type="radio"/>		Computer Server & System Maintenance	42,020		13,689	16	
Creative Financial Staffing		<input type="radio"/>	<input checked="" type="radio"/>		Temp Bookkeeping & Accounting Services	78,827		25,680	16	
Paylocity		<input type="radio"/>	<input checked="" type="radio"/>		Payroll Processing	13,026		4,243	16	
Clifton Lawson Allen		<input type="radio"/>	<input checked="" type="radio"/>		Administrative Consultant	15,410		5,020	16	
		<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 9/30/2021			Page 22	of 37
Item		Total	CCNH	RHNS	Residential Care Home	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	15,660	8,905			6,755
b. Heat	\$	27,483	15,628			11,855
c. Light & Power	\$	97,953	55,700			42,253
d. Water	\$	18,871	10,731			8,140
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$	821	467			354
f. Other <i>(itemize)</i>	\$	123,651	75,831			47,820
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	284,439	167,262			117,177
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$	20,394	11,597			8,797
b. Building & Building Improvements	\$	294,450	167,435			127,015
c. Non-Movable Equipment	\$	19,898	11,315			8,583
d. Movable Equipment	\$	75,606	42,993			32,613
*7e. Total Depreciation Costs (7a + b + c + d)	\$	410,348	233,340			177,008
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$	7,947	4,519			3,428
c. Leasehold Improvements	\$					
d. Other <i>(Specify)</i>	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$	7,947	4,519			3,428
9. Rental payments on leased real property less real estate taxes included in item 10b	\$					
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$					
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	418,295	237,859			180,436

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	Residential Care Home
Purchased Service - Plumber	\$ 2,277		\$ 1,728
Purch Service - HVAC	\$ 7,284		\$ 5,525
Purchased Services - Electric	\$ 1,703		\$ 1,292
Purch Serv - Exterminator	\$ 1,089		\$ 826
Purchased Serv - Alarm Service	\$ 652		\$ 495
Purch Service - Fire Protecti	\$ 5,001		\$ 3,794
Purch Serv - Sec camera Main	\$ 2,557		\$ 1,939
Purch Service - Ridgefield As	\$ 4,777		\$ 3,623
Purch Service - Elevator	\$ 2,446		\$ 1,855
Purchased Service - Fire Cont	\$ 41		\$ 31
Purch Service - Telephone Rep	\$ 3,219		\$ 2,442
Purch Serv - Nurse Call System	\$ 1,257		\$ 953
Purchased Service - Shredding	\$ 4,024		\$ -
Purchased Service - Generator	\$ 3,000		\$ 2,276
Purch Serv - Snow Removal	\$ 11,259		\$ 8,541
Purch Service - Med Equip Ins	\$ 694		\$ 526
Purch Services - Legionella Rist Ass	\$ -		\$ -
Trash Removal- Maint	\$ 5,610		\$ 4,256
Medical Waste Removal	\$ 1,820		\$ -
Landscaping	\$ 4,943		\$ 3,750
Office Equip Maint Agreements	\$ 12,011		\$ 3,913
Minor Off.Equip Repair & Repl	\$ 167		\$ 55
Total Other Repairs and Maintenance	\$ 75,831	\$ -	\$ 47,820

Depreciation Schedule

Name of Facility Leeway, Inc.				License No. 2167-C			Report for Year Ended 9/30/2021				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	
A. Land Improvements												
1. Acquired prior to this report period				305,769		305,769	108,941	SL	Var	20,394		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal											20,394	
B. Building and Building Improvements												
1. Acquired prior to this report period				8,098,748		8,098,748	4,087,007	SL	Var	294,222		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)				6,830		6,830		SL	Var	228		
B-4. Subtotal											294,450	
C. Non-Movable Equipment												
1. Acquired prior to this report period				336,346		336,346	179,994	SL	Var	19,898		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
C-4. Subtotal											19,898	
	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. Movable Equipment												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. 2005 Mazda	x		4	2007	14,983		14,983	14,983	SL	5		
b. 2017 Ford Bus	x		8	2017	68,717		68,717	46,765	SL	6	11,453	
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					709,842		709,842	446,034	SL	var	58,146	
b. Disposals (attach schedule)					(4,477)		(4,477)					
c. Acquired during this report period (attach schedule)					87,705		87,705		SL	var	6,007	
D-3. Subtotal											75,606	
E. Total Depreciation											410,348	

Schedule of Land Improvements Acquired during this report period

*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:				
7/19/2021	Roofed Right America - roof repair	\$ 3,350	15	\$ 112
8/16/2021	ABC Supply Co	\$ 570	15	\$ 19
9/23/2021	East Shore Glass - desk barriers	\$ 2,910	15	\$ 97
Total additions for Building Improvement		\$ 6,830		\$ 228 *
Deletions:				
Total deletions for Building Improvement		\$ -		\$ - ***

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

**Ties to Page 23, Line C3

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
11/20/2020	EBM IT Computers	\$ 3,747	5	\$ 375
12/29/2020	Apollo Refrigeration (replaced Warehouse Store Fixture)	\$ 5,750	10	\$ 288
1/13/2021	EBM IT Computers	\$ 28,682	5	\$ 2,868
12/31/2020	Vocera (enhanced communications project)	\$ 33,494	10	\$ 1,675
2/22/2021	Vocera (enhanced communications project)	\$ 2,967	10	\$ 148
3/18/2021	Vocera (enhanced communications project)	\$ 5,355	10	\$ 268
3/31/2021	McKesson Medical - air mattresses	\$ 2,395	10	\$ 120
5/26/2021	F&W Equipment Corp - deposit for tractor snow plow	\$ 1,000	10	\$ 50
6/24/2021	McKesson Medical - stretcher with back rest	\$ 2,125	10	\$ 106
9/3/2021	H&R Healthcare - wheelchairs	\$ 2,190	10	\$ 110
Total additions for Movable Equipment		\$ 87,705		\$ 6,007 *
Deletions:				
	Warehouse Store Fixture purchased 2011; retired replaced by Apollo Refrig	\$ (4,477)		
Total deletions for Movable Equipment		\$ (4,477)		\$ - **

*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:				
Total additions for Leasehold Improvements		\$ -		\$ - *
Deletions:				
Total deletions for Leasehold Improvements		\$ -		\$ - **

*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 9/30/2021			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							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1. Financing Costs - Key Bank #1	12	2014	15	20,361	11,707	SL		2,036	
2. Financing Costs - Key Bank #2	12	2014	20	59,107	28,077	SL		5,911	
3.									
B-4. Subtotal									7,947
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									7,947

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2021	Page 25	of 37
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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				
7. Acquisition Cost				
a. Land				
b. Building				

Part B - Owner and Related Parties

	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Variable	Fixed		
b. Date Mortgage Obtained	12/24/14	12/24/14		
c. Interest Rate for the Cost Year	Variable	5.00%		
d. Term of Mortgage (number of years)	15	20		
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____	313,309	2,474,313		

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.

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

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2021			Page 26 37
Item		Total	CCNH	RHNS	Residential Care Home
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	\$	14991	8,524		6,467
Name of Lender Key Bank	Rate Variable				
Address of Lender					
2. Second Mortgage	\$	147,009	83,595		63,414
Name of Lender Key Bank	Rate 5.00%				
Address of Lender					
3. Third Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
B. CHEFA Loan Information					
1. Original Loan Amount	\$				
2. Loan Origination Date					
3. Interest Rate %					
4. Term					
5. CHEFA Interest Expense					
12 B7. Total Building Interest Expense (A1 - A4 + B5)	\$	162,000	92,119		69,881

(Carry Subtotals forward to next page)

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

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2021			Page 27	of 37
Item			Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:			162,000	92,119		69,881
12. C. Movable Equipment						
1. Automotive Equipment			\$ 320	182		138
A. Item 2017 Ford Van/Bus	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)			\$ 320	182		138
12. D. Other Interest Expense (Specify) Working Capital			\$ 1,544	878		666
13. Total All Interest Expense (12B7 + 12C3 + 12D)			\$ 163,864	93,179		70,685
14. Insurance						
a. Insurance on Property (buildings only)			\$ 22,811	11,293		11,518
b. Insurance on Automobiles			\$ 11,816	5,850		5,966
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)			\$ 33,626	26,658		6,968
2. Fire and Extended Coverage			\$			
3. Other (Specify)			\$ 29,467	23,361		6,106
Fid. Bond, Cyber, D&O, Crime						
14d. Total Insurance Expenditures (14a + b + c)			\$ 97,720	67,162		30,558
15. Total All Expenditures (A-13 thru C-14)			\$ 7,370,123	5,482,561		1,887,562

D. Adjustments to Statement of Expenditures

Name of Facility Leeway, Inc.			License No. 2167-C	Report for Year Ended 9/30/2021		Page 28 of 37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
<i>Page 10 - Salaries and Wages</i>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10		Occupational Therapy	\$ 42,270	42,270		
4.			Other - See attached Schedule	\$			
<i>Page 13 - Professional Fees</i>							
5.			Resident Care Physicians **	\$			
6.	13	B.10.	Occupational Therapy	\$ 6,878	6,878		
7.			Other - See attached Schedule	\$			
<i>Pages 15 & 16 - Administrative and General</i>							
8.			Discriminatory Benefits	\$			
9.	15	1.c	Bad Debts	\$ 16,620	12,964		3,656
10.			Accounting	\$			
10a.			Legal	\$ 158	119		39
11.	15		Telephone	\$ 2,921			2,921
12.			Cellular Telephone	\$ 3,545	1,755		1,790
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.			Unallowable Advertising *	\$			
19.			Income Tax / Corporate Business Tax	\$			
20.	16	m.4	Fund Raising / Contributions	\$ 71,165	53,678		17,487
21.			Unallowable Management Fees	\$			
22.	16	m.6	Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ (76,565)	(55,806)		(20,759)
<i>Page 18 - Dietary Expenditures</i>							
24.	30		Meals to employees, guests and others who are not residents	\$ 5,277	2,613		2,664
<i>Page 19 - Laundry Expenditures</i>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<i>Page 20 - Housekeeping Expenditures</i>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$ 72,269	64,471			7,798

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
16		Cable TV	\$ 7,914		\$ -
		Penalties And Late Fees	\$ 54		\$ 17
		Lobbying Expenses	\$ 10,748		\$ 3,502
		Barber & Beauty	\$ 492		\$ 160
		Credit Card Fees	\$ 2,197		\$ 716
		Resident Personal Items	\$ 280		\$ 91
		Swap Expense	\$ (79,416)		\$ (25,872)
		2002 Ford Insurance, gas & repair	\$ 968		\$ 316
		2007 Mazda Insurance, gas & repair	\$ 23		\$ 7
		Chamber of Commerce	\$ 934		\$ 304
Total Other A&G Adjustments			\$ (55,806)	\$ -	\$ (20,759)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-29 Rev. 9/2018

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

Name of Facility Leeway, Inc.			License No. 2167-C	Report for Year Ended 9/30/2021		Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
			Subtotals Brought Forward	\$ 72,269	64,471		7,798
<i>Page 20 - Resident Care Supplies***</i>							
27.			Prescription Drugs	\$ 168,409	168,409		
28.			Ambulance/Limousine	\$ 2,174	2,174		
29.			X-rays, etc	\$ 3,283	3,283		
30.			Laboratory	\$ 8,407	8,407		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 240	240		
<i>Page 22 - Maintenance and Property</i>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
<i>Page 27 - Insurance</i>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<i>Other - Miscellaneous</i>							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ 9,447	750		8,697
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<i>Not For Profit Providers Only</i>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 264,229	247,734		16,495

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

Schedule of Other Ancillary Costs

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Schedule of Other - Indirect Adjustments

Attachment Page 29

Schedule of Other - Miscellaneous Administrative Adjustments

Schedule of Other - Direct Adjustments

Schedule of Unallowable Building Interest

Total Unallowable Building Interest	\$ -	\$ -	\$ -
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F. Statement of Revenue

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2021			Page 30 37
Item		Total	CCNH	RHNS	Residential Care Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 5,997,909	4,234,500			1,763,409
b. Medicaid Room and Board Contractual Allowance **	\$ (100,746)	65,843			(166,589)
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 504,737	504,737			
b. Medicare Room and Board Contractual Allowance **	\$ 999,157	999,157			
4. a. Private-Pay Residents and Other	\$ 62,050				62,050
b. Private-Pay Room and Board Contractual Allowance **	\$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 144,891	144,891			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (144,891)	(144,891)			
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	\$ 103,530	103,530			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (71,999)	(71,999)			
c. Physical Therapy - Non-Medicare	\$ 40,635	40,635			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (40,404)	(40,404)			
4. a. Speech Therapy - Medicare	\$ 44,283	44,283			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (26,391)	(26,391)			
c. Speech Therapy - Non-Medicare	\$ 36,553	36,553			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (36,443)	(36,443)			
5. a. Occupational Therapy - Medicare	\$ 78,753	78,753			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (52,437)	(52,437)			
c. Occupational Therapy - Non-Medicare	\$ 25,179	25,179			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (25,177)	(25,177)			
6. a. Other (<i>Specify</i>) - Medicare	\$ 7,597	7,597			
b. Other (<i>Specify</i>) - Non-Medicare	\$ (4,851)	(4,851)			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 7,541,935	5,883,065			1,658,870
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$ 5,277	2,613			2,664
2. Rental of rooms to non-residents	\$				
3. Telephone	\$ 2,921				2,921
4. Rental of Television and Cable Services	\$ 8,447				8,447
5. Interest Income (<i>Specify</i>)	\$ 288	143			145
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ 695,602	522,150			173,452
V. Total Other Revenue (1 thru 8)	\$ 712,535	524,906			187,629
VI. Total All Revenue (III +V)	\$ 8,254,470	6,407,971			1,846,499

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

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

Schedule of Other Resident Revenue - Medicare**Related Exp**

Page Ref	Description	CCNH	RHNS	Residential Care Home
30	Radiology-Medicare	\$ 1,388		
30	Radiology Revenue Medicare Replacement	\$ 286		
30	Lab- Medicare	\$ 4,249		
30	Lab Revenue Medicare Replacement	\$ 1,674		
Total Other Resident Revenue - Medicare		\$ 7,597	\$ -	\$ -

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

Page Ref	Description	CCNH	RHNS	Residential Care Home
	Contractual Allowances	\$ (4,851)		
Total Other Resident Revenue		\$ (4,851)	\$ -	\$ -

Interest Income**Account**

Page Ref	Account	Balance	CCNH	RHNS	Residential Care Home
30	Money Market Account	\$ 143			\$ 145
Total Interest Income		\$ 143	\$ -	\$ -	\$ 145

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
30	PPD Loan Forgiveness	\$ 474,412		\$ 154,553
30	Restricted Donations - Rec De	\$ 495		\$ 505
30	Fund Raiser-Annual Appeal	\$ 3,758		\$ 3,832
30	Donations - Unrestricted	\$ 43,387		\$ 14,462
30	Donations - United Way	\$ 98		\$ 100
Total Other Revenue		\$ 522,150	\$ -	\$ 173,452

G. Balance Sheet

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2021	Page 31	of 37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$ 932,313	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 644,651	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$ 23,676	
4. Inventories			\$	
5. Prepaid Expenses			\$ 35,608	
a. _____				
b. _____				
c. _____				
d. See Schedule		35,608		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$ 628,905	
See Schedule		628,905		
A-9. Total Current Assets (Lines A1 thru 8)			\$ 2,265,153	
B. Fixed Assets				
1. Land			\$ 581,784	
2. Land Improvements	*Historical Cost	305,769	\$ 176,434	
	Accum. Depreciation	129,335	Net	
3. Buildings	*Historical Cost	8,105,578	\$ 3,724,121	
	Accum. Depreciation	4,381,457	Net	
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	336,346	\$ 136,454	
	Accum. Depreciation	199,892	Net	
6. Movable Equipment	*Historical Cost	793,070	\$ 282,883	
	Accum. Depreciation	510,187	Net	
7. Motor Vehicles	*Historical Cost	83,700	\$ 10,499	
	Accum. Depreciation	73,201	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$ 2,194,410	
See Schedule		2,194,410		
B-10. Total Fixed Assets (Lines B1 thru 9)			\$ 7,106,585	

* 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	\$ 34,443
		Prepaid Dues	\$ (612)
		Prepaid Maintenance	\$ 3,172
		Prepaid Fire Alarm Service	\$ (1,395)
		Total Prepaid Expenses	\$ 35,608

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

Page Ref	Line Ref	Description	
		PPP SBA Loan Reserve	\$ 628,905
		Total Other Current Assets (Itemize)	\$ 628,905

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

Page Ref	Line Ref	Description	
		Assets(net of Depreciation) - Non Reimbursable	\$ 2,192,950
		CIP Elevator Project	\$ 1,460
		Total Other Other Fixed Assets (Itemize)	\$ 2,194,410

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Board Designated Fund	\$ 302,012
		Deferred Financing - Key Bank Mortgage	\$ 20,361
		Deferred Financing - Key Bank Construction Mortgage	\$ 59,107
		Accumulated Deferred Financing Amortization - #1	\$ (13,744)
		Accumulated Deferred Financing Amortization - #2	\$ (33,987)
		Total Other Assets	\$ 333,749

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	
		Resident Trust	\$ 64,664
		Accrued Provider Tax	\$ 62,776
		Deferred Income - HOPWA	\$ (1,487)
		Deferred Income - DMHAS	29511
		Deferred Income - DSS Community Case Management	255781
		Total Other Current Liabilities (Itemize)	\$ 411,245

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

Page Ref	Line Ref	Description	
		DSS Bond Advances	\$ 1,275,000
		Mortgage Swap Liability - 1st Mortgage	\$ 5,088
		Mortgage Swap Liability - 2nd Mortgage	\$ 162,579
		Total Other Current Liabilities (Itemize)	\$ 1,442,667

G. Balance Sheet (cont'd)

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2021	Page 32	of 37
Account		Amount		
		Total Brought Forward:		\$ 9,371,738
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 (<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>)				\$ 333,749
See Schedule	333,749			
D-8. Total Investments and Other Assets (Lines D1 thru 7)				\$ 333,749
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)				\$ 9,705,487

* 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 9/30/2021	Page 33	of 37					
Account				Amount					
Liabilities									
A. Current Liabilities									
1. Trade Accounts Payable				\$ 360,919					
2. Notes Payable (<i>itemize</i>)				\$					
See Schedule									
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$					
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; padding: 2px;">Name of Lender</th> <th style="text-align: left; padding: 2px;">Purpose</th> <th style="text-align: left; padding: 2px;">Amount</th> <th style="text-align: left; padding: 2px;">Date Due</th> <th style="text-align: left; padding: 2px;"></th> </tr> </thead> </table>					Name of Lender	Purpose	Amount	Date Due	
Name of Lender	Purpose	Amount	Date Due						
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$ 68,387					
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$					
6. Accrued Payroll Taxes Payable				\$ 10,432					
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>)				\$ 411,245					
See Schedule				411,245					
A-13. Total Current Liabilities (Lines A1 thru 12)				\$ 850,983					

* 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 9/30/2021	Page 34	of 37
Account			Amount	
Total Brought Forward:			850,983	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)			\$	
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable			\$	2,787,622
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>)			\$	1,442,667
See Schedule	1,442,667			
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$	4,230,289
C. Total All Liabilities (Lines A-13 + B-5)			\$	5,081,272

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

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2021	Page 35	of 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 (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	3,556,586
6. Gain or Loss for Period	10/1/2020	thru	9/30/2021	\$ 1,067,629
7. Total Net Worth			\$	4,624,215
C. Total Reserves and Net Worth			\$	4,624,215
D. Total Liabilities, Reserves, and Net Worth			\$	9,705,487

H. Changes in Total Net Worth

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2021	Page 36	of 37
Account				Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2020			\$	3,346,995
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	8,254,470
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	7,370,123
D. Net Income or Deficit			\$	884,347
E. Balance			\$	4,440,932
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
Grant, Housing & non-Reimbursable Related Rev		737,737		
Grant, Housing & non-Reimbursable Related Exp		(554,455)		
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	183,282
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	
Name and Address (No., City, State, Zip)		Title	Amount	
2. Other Withdrawals (<i>Specify</i>)			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period	09/30/21		\$	4,624,214

I. Preparer's/Reviewer's Certification

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2021	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> Residential Care Home		

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
Printed Name of Preparer		
Robert Morgan, CPA		
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Contacted Person Regarding Additional Information Needed Regarding This Report Roland Beneke		Phone Number 203 865-0068
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