State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2015

Name of Facility (as licensed) Leeway, Inc.		
Address (No. & Street, City, State, Zip Code) 40 Albert St., New Haven, Ct 06511		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☑ Residential Care Home		
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015	

License Numbers:	CCNH	RHNS	Residential Care Home	Medicare Provider
	2167-C		1891-RCH	07-5408

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID

For Department Use Only

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

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General Information

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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 IMPRISIONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Leeway, Inc. [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, 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) Heather Aaron			Printed Name (Owner) Heather Aaron, CEO	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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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 10/1/2014	To 9/30/2015
Address of Facility 40 Albert St., New Haven, Ct 06511				
Report Prepared By Robert Morgan	Phone Number 203 865-0068		Date 2/15/2016	

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.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203 865-0068	9/30/2015	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Leeway, Inc.	40 Albert St., New Haven, Ct 06511

	CCNH	RHNS	Residential Care Home	Medicare Provider No.
License Numbers:	2167-C		1891-RCH	07-5408

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☑ Residential Care Home

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
Heather Aaron		001635

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
N/A		

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Leeway, Inc	40 Albert St, New Haven, Ct	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
William Dyson		President	
Patricia Comer		Vice President	
Pamala Brooks		Secretary	
Gary Richter		Treasurer	
Names of Stockholders Owning at Least 10% of Shares			
Non-Profit 501 C(3)			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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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	%**				
		○	⊙					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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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 (*See listing page 13*)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

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

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

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

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.

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General Information and Questionnaire
Leases (Excluding Real Property)

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

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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Pitney Bowes	○	⊙	Postage Machine	03/30/11	60 Months	550	550
DeLage Landen	○	⊙	Savin 917 SPF Fax Machines (2)	08/01/10	Terminated 8/1/2015	1,344	1,714
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ⊙ Yes ○ No **Total ***** 2,264

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

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
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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	Address (No. & Street, City, State, Zip Code)
1 Blum Shapiro	
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Year End Audit & form 990	$ 32,047
2		$
3		$
4		$
	Charge for Services Provided	$ 32,047

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	Telephone Number
1 Greentree Risk Management	
2 Katherine Sacks	
3 Federal Insurance Company	
4 Neubert, Pepe & Monteith	
5	

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	Employment & Labor Relations Consultant	$ 3,000
2	General Corporate Matters & Health Department related issues	$ 23,305
3	Employee EEO Lawsuit - Retention	$ 126
4	Physician Billing & Practice Regulations Research.	$ 130
5		$
	Charge for Services Provided	$ 26,561

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

⊙ Yes ○ No

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH 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	40	30		10	40	30		10	40	30		10
B. On last day of THIS report period	40	30		10	40	30		10	40	30		10
2. Number of Residents												
A. As of midnight of PREVIOUS report period	37	27		10	37	27		10	39	29		10
B. As of midnight of THIS report period	39	29		10	39	29		10	39	29		10
3. Total Number of Days Care Provided During Period												
A. Medicare	492	492			361	361			131	131		
B. Medicaid (Conn.)	10,020	10,020			7,504	7,504			2,516	2,516		
C. Medicaid (other states)												
D. Private Pay												
E. State SSI for RCH	3,518			3,518	2,600			2,600	918			918
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	14,030	10,512		3,518	10,465	7,865		2,600	3,565	2,647		918
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)**	14,030	10,512		3,518	10,465	7,865		2,600	3,565	2,647		918

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Schedule of Resident Statistics (Cont'd)

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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	Residential Care Home	Lost			Gained			CCNH	RHNS	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	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	26					10	
Per Diem Rate								
a. One bed rm.		395.00		450.00		210.00	185.00	
b. Two bed rms.								
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	Residential Care Home
A. Medicare - Part B	410	410		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,523	1,523		
2. Restorative Treatments				
C. Other	969	969		
D. ***Total Physical Therapy Treatments***	2,902	2,902		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	42	42		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	272	272		
2. Restorative Treatments				
C. Other	119	119		
D. ***Total Speech Therapy Treatments***	433	433		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	245	245		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,460	1,460		
2. Restorative Treatments				
C. Other	998	998		
D. ***Total Occupational Therapy Treatments***	2,703	2,703		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	131,743	1,586			14,638	176
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	32,476	1,438			3,608	160
5. Dietary Service						
a. Head Dietitian	8,263	232			2,771	78
b. Food Service Supervisor	45,527	1,576			15,267	528
c. Dietary Workers	171,447	10,504			57,492	3,523
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	35,467	1,193			10,254	345
b. Other Maintenance Workers						
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services	93,577	91,148			27,055	26,353
11. Accounting Services						
a. Head Accountant	92,990	1,634			10,332	182
b. Other Accountants	119,670	4,711			13,297	524
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	105,626	2,080				
b. RN						
1. Direct Care	405,504	10,603				
2. Administrative**	145,192	3,983				
c. LPN						
1. Direct Care	292,737	9,108				
2. Administrative**						
d. Aides and Attendants	475,668	24,672			146,853	9,757
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	37,898	1,654			12,709	554
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	61,275	1,605			20,548	538
n. Marketing						
o. Other (Specify)						
See Attached Schedule	6,554	315			2,198	106
A-13. Total Salary Expenditures	2,261,614	168,042			337,022	42,824

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		Residential Care Home	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Chaplain	$ 6,554	315	$ -	-	$ 2,198	106
Total	$ 6,554	315	$ -	-	$ 2,198	106

Schedule of Other Fees (Page 13)

	CCNH		RHNS		Residential Care Home	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

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

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

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Residential Care Home							
Section III - Administrators* **										
Heather Aaron	131,743		14,638	Std Employee Benefits	Administrator of Facility	1,762	A.2	DMHAS & Housing	318	23,757
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2015	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist	2,275	48				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	82,868	1,672				
b. Other						
6. Social Worker	31,576	1,736			10,588	582
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	40,079	272				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	230					
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	17,862	275				
b. Other						
10. Occupational Therapist						
a. Resident Care	53,896	1,078				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	115,237	1,440				
2. Administrative***	24,763	496				
b. LPN						
1. Direct Care	44,513	927				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	413,299	7,945			10,588	582

* 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2015	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Thomas Kidder, LCSW	LCSW	○	⊙	
Richard Feldman, DPM	Podiatrist	○	⊙	
Foremost Rehab	Therapy Services	○	⊙	
Peter Selwyn, MD, Guilford, Ct	Medical Director	○	⊙	
Anuruddha Walaliyadda, MD	Medical Director	○	⊙	
Northeast Medical Group	Physicians / Med Staff Admin	○	⊙	
Med Stat Pharmacy	Pharmacy Consultant	○	⊙	
Nurse Network	RN, LPN & C.N.A. Per Diem Staff	○	⊙	
Mary Lord, RN	MDS Consultant	○	⊙	
David Clark, RN	MDS Consultant	○	⊙	
Maxim Staffing	RN, LPN & C.N.A. Per Diem Staff	○	⊙	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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C. Expenditures Other Than Salaries - Administrative and General

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Item		Total	CCNH	RHNS	Residential Care Home
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	67,250	58,528		8,722
2. Disability Insurance	$				
3. Unemployment Insurance	$	39,082	34,013		5,069
4. Social Security (F.I.C.A.)	$	190,284	165,606		24,678
5. Health Insurance	$	195,039	169,745		25,294
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	73,700	64,141		9,559
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	(13,273)	(11,552)		(1,721)
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	22,000	22,000		
d. Accounting and Auditing	$	32,047	28,842		3,205
e. Legal (*Services should be fully described on Page 7)*	$	26,562	23,906		2,656
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	25,632	23,069		2,563
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	26,020	23,418		2,602
2. Cellular Phones	$	658	592		66
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	203,248	203,248		
Subtotal	$	888,249	805,556		82,693

* 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**

Leeway, Inc. Attachment Page 15
9/30/2015

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Residential Care Home
Emp. Benefit Alloc - DMHAS/Ho	$ (7,126)	$ -	$ (1,062)
Emp Ben Alloc - DOH Grant	$ (4,565)	$ -	$ (680)
Employee Assistance Program	$ 139	$ -	$ 21
Total	$ (11,552)	$ -	$ (1,721)

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2015	16	37

Item		Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:		888,249	805,556		82,693
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$	2,836	2,552		284
4. Employee Travel	$	2,016	1,814		202
5. Education Expenses Related to Seminars and Conventions	$	3,747	3,372		375
6. Automobile Expense (*not purchase or depreciation*)	$	3,292	2,963		329
7. Other (*Specify*)	$	1,924	1,732		192
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	186	167		19
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	214	193		21
See Attached Schedule					
4. Fund-Raising***	$	6,721	6,049		672
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	2,420	2,178		242
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	6,595	5,934		661
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	2,387	2,148		239
10. Contributions*** See Attached Schedule	$	500	374		126
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	137,483	125,176		12,307
12. Administrative Management Services**	$				
13. Other (*Specify*) See Attached Schedule	$	277,802	250,023		27,779
C-14 Total Administrative & General Expenditures	$	1,336,372	1,210,231		126,141

* 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
Staff Training Expense	$ 1,732	$ -	$ 192
Total Other Travel and Entertainment	$ 1,732	$ -	$ 192

Schedule of Other Advertising

Description	CCNH	RHNS	Residential Care Home
Advertising Other	$ 193	$ -	$ 21
Total Other Advertising	$ 193	$ -	$ 21

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
Leading Age	$ 3,200	$ -	$ 356
ALTCFM	$ 144	$ -	$ 16
ACHCA	$ 279	$ -	$ 31
ACT Aids CT	$ 270	$ -	$ 30
AICPA / CSCPA	$ 445	$ -	$ 50
Dun & Bradstreet	$ 989	$ -	$ 110
CBIA	$ 540	$ -	$ 60
BJ	$ 67	$ -	$ 8
Total Dues	$ 5,934	$ -	$ 661

Schedule of Contributions

Description	CCNH	RHNS	Residential Care Home
New Haven Police & Firefighters	$ 374	$ -	$ 126
Total Contributions	$ 374	$ -	$ 126

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
Management & Board Retreat	$ 187	$ -	$ 21
Licenses & Fees	$ 3,169	$ -	$ 352
Bank Charges	$ 2,699	$ -	$ 300
New Employee Hire	$ 16,042	$ -	$ 1,782
Health & Drug Screening	$ 1,770	$ -	$ 197
Employee Background Checks	$ 576	$ -	$ 64
Nursing Home Week Celebration	$ 2,520	$ -	$ 280
Volunteer Appreciation	$ 1,279	$ -	$ 142
Computer Supplies & Minor Equ	$ 5,663	$ -	$ 629
Cable TV - Allowable	$ 3,240	$ -	$ 360
Employee Service Awards	$ 646	$ -	$ 72
Self Disallowances:	$ -	$ -	$ -
Cable TV	$ 5,778	$ -	$ 642
Penalties And Late Fees	$ 1,063	$ -	$ 118
Lobbying Expenses	$ 10,125	$ -	$ 1,125
Entertainment	$ 76	$ -	$ 8
Alumni Expenses	$ 936	$ -	$ 104
Professional Fees	$ 7,200	$ -	$ 800
Resident Personal Items	$ 931	$ -	$ 103
Patient Expense	$ 107	$ -	$ 12
Prior Year Expense	$ 1,926	$ -	$ 214
Swap Expense	$ 180,328	$ -	$ 20,036
Non-Reimburseable	$ 3,108	$ -	$ 345
Credit Card Transaction Fees	$ 654	$ -	$ 73
DMHAS Housing Case Management Costs:	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
Total Other Administrative and General	$ 250,023	$ -	$ 27,779

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Schedule C-1 - Management Services*

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2015	Page 17 of 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Leeway, Inc.	2167-C	9/30/2015	18 | 37

Item		Total	CCNH	RHNS	Residential Care Home
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	123,623	92,578		31,045
2. Non-Food Supplies	$	16,564	12,404		4,160
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	5,587	4,184		1,403
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	145,774	109,166		36,608

2F. Dietary Questionnaire		Total	CCNH	RHNS	Residential Care Home
G. Resident Meals:	Total no. of meals served per day:*	116	87		29

H.	Is cost of employee meals included in 2E?	⊙ Yes	○ No		
I.	Did you receive revenue from employees?	⊙ Yes	○ No	If yes, specify amt.	$1,699
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				P30, L IV 1
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	⊙ Yes	○ No	If yes, specify cost.	$2,493
L.	Is any revenue collected from these people?	⊙ Yes	○ No	If yes, specify amt.	$2,493
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				P30, L IV 1
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.	
O.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.	
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.
** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Name of Facility Leeway, Inc.	License No. 2167-C	Report for Year Ended 9/30/2015		Page of 19 | 37

Item		Total	CCNH	RHNS	Residential Care Home
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	Amt. $	944	826		118
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	28,552	24,983		3,569
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	29,496	25,809		3,687

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

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2015	20	37

Item			Total	CCNH	RHNS	Residential Care Home
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	17,894	16,466		1,428
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	141,461	130,158		11,303
c. Management Services*		$				
d. Other (*Specify*)		$	4,926	3,821		1,105
Minor Equipment & Furnishing						
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	164,281	150,445		13,836
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$				
MedStat Pharmacy						
b. Medicine Cabinet Drugs		$	17,180	17,180		
c. Medical and Therapeutic Supplies		$	78,641	78,641		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	7,258	7,258		
f. X-rays and Related Radiological Procedures***		$	1,632	1,632		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	4,342	4,342		
i. Recreation		$	20,412	15,286		5,126
j. Other (Specify)****		$	11,695	11,695		
See Attached Schedule						
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	141,160	136,034		5,126

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	Residential Care Home
Medical Equip Rental - T19	$ 6,318	$ -	$ -
Medical Equip Rental-MR	$ 270	$ -	$ -
Equip Rental - Medicare	$ 180	$ -	$ -
Equip Rental - T-19	$ 2,295	$ -	$ -
Minor Equip & Furniture	$ 2,632	$ -	$ -
-			
Total Other Resident Care	$ 11,695	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2015	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
Unitex		○	⊙		Laundry Service	24,983		3,569	19	c.3.b
John's Refuse		○	⊙		Rubbish Removal	5,966		1,725	22	c.6.f
VCPI		○	⊙		IT Support and Computer Server Administrator	34,345		3,816	16	C.1.m
Creative Financial Staffing		○	⊙		Temporary Business Office Staff	11,803		1,311	16	C.1.m
Check Writers		○	⊙		Payroll Processing Fees	9,441		1,049	16	C.1.m
Diversified Building Services		○	⊙		Housekeeping	130,158		11,303	20	C.4.b
Securitas Security Services USA		○	⊙		Security Service	28,046		8,108	22	C.6.f
Creative Financial Staffing		○	⊙		Temporary Office Staff	9,367		1,041	16	C.1.m
Point Click Care		○	⊙		Software User Fee - Point Click Care	14,197		1,577	16	C.1.m
One Source Property Management		○	⊙		Property Management Staff - Full Time Director	16,631		4,808	22	C.6.f
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Leeway, Inc.	2167-C	9/30/2015	22 | 37

Item		Total	CCNH	RHNS	Residential Care Home
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	25,880	20,076		5,804
b. Heat	$	14,415	11,182		3,233
c. Light & Power	$	81,488	63,212		18,276
d. Water	$	13,305	10,321		2,984
e. Equipment Lease (*Provide detail on page 6*)	$	2,264	1,757		507
f. Other (*itemize*)	$	186,934	146,791		40,143
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	324,286	253,339		70,947
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	9,088	7,050		2,038
b. Building & Building Improvements	$	184,075	142,791		41,284
c. Non-Movable Equipment	$	13,993	10,855		3,138
d. Movable Equipment	$	44,619	34,612		10,007
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	251,775	195,308		56,467
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	14,226	11,035		3,191
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	14,226	11,035		3,191
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	$	680	527		153
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	649	503		146
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	267,330	207,373		59,957

* 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
One Source Contract	$ 16,631	$ -	$ 4,808
Purchased Service - Plumber	$ 3,447	$ -	$ 996
Purch Service - HVAC	$ 8,851	$ -	$ 2,559
Purchased Services - Electric	$ 1,500	$ -	$ 434
Purch Serv - Exterminator	$ 1,501	$ -	$ 434
Purchased Serv - Alarm Service	$ 3,222	$ -	$ 931
Purch Service - Fire Protecti	$ 4,759	$ -	$ 1,376
Purch Serv - Sec camera Main	$ 3,085	$ -	$ 892
Purch Service - Ridgefield As	$ 7,137	$ -	$ 2,063
Purch Service - Elevator	$ 1,995	$ -	$ 577
Purchased Service - Locksmith	$ 4,544	$ -	$ 1,314
Purch Service - Telephone Rep	$ 6,055	$ -	$ 1,750
Purchased Service - Shredding	$ 2,100	$ -	$ 607
Purchased Service - Generator	$ 1,714	$ -	$ 496
Purch Serv - Snow Removal	$ 8,797	$ -	$ 2,543
Purch Service - Med Equip Ins	$ 5,960	$ -	$ -
Purchased Services - Painting	$ 14,834	$ -	$ 4,289
Aquarium Services	$ 1,323	$ -	$ 382
Trash Removal- Maint	$ 5,966	$ -	$ 1,725
Medical Waste Removal	$ 1,974	$ -	$ -
Landscaping	$ 4,006	$ -	$ 1,158
Office Equip Maint Agreements	$ 6,081	$ -	$ 1,758
Office Minor Equip Repair & R	$ 3,263	$ -	$ 943
Security Contracted Service	$ 28,046	$ -	$ 8,108
Total Other Repairs and Maintenance	$ 146,791	$ -	$ 40,143

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2015	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	129,431		129,431	18,453	SL	Var	8,945	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	4,289		4,289		SL	15	143	
A-4. Subtotal								9,088
B. **Building and Building Improvements**								
1. Acquired prior to this report period	4,628,566		4,628,566	2,463,342	SL	Var	183,431	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	25,739		25,739		SL	20	644	
B-4. Subtotal								184,075
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	212,043		212,043	75,795	SL	Var	13,874	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	3,555		3,555		SL	15	119	
C-4. Subtotal								13,993

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b. 2005 Mazda	x		Apr	2007	14,983		14,983	14,983	SL	5		
c. Van	x		Apr	2010	9,974		9,974	9,974	SL	3		
d.												
2. Movable Equipment												
a. Acquired prior to this report period					733,226		733,226	469,518	SL	Var	41,357	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					33,507		33,507		SL	Var	3,262	
D-3. Subtotal												44,619
E. ***Total Depreciation***												251,775

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Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
11/11/2014	Fence - Reliable Fence Co.	$ 4,289	15	$ 143	
Total additions for Land Improvements		$ 4,289		$ 143	*
Deletions:					
Total deletions for Land Improvements		$ -		$ -	**

***Ties to Page 23, Line A3**
****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
8/4/2015	Wheelchair Charging Room - Wm Fisher	$ 15,379	20	$ 384	
3/6/2015	Wander Guard upgrade - Advanced Alarm	$ 5,380	20	$ 135	
4/7/2015	Electrical Wiring - Odell McNair	$ 4,980	20	$ 125	
Total additions for Building Improvements		$ 25,739		$ 644	*
Deletions:					
Total deletions for Building Improvements		$ -		$ -	**

***Ties to Page 23, Line B3**
****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
	Laundry Hook-up - Izbicki Contracting	$ 1,800	15	$ 60	
	Upgrade Kitchen Hood - Fire Control Service	$ 1,755	15	$ 59	
Total additions for Non-Movable Equipment		$ 3,555		$ 119	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

***Ties to Page 23, Line C3**
****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
4/2/2015	BP/Temp/Oxm Cart - McKesson	$ 2,449	10	$ 122	
4/8/2015	Air Mattress - McKesson	$ 2,110	10	$ 106	
4/10/2015	Air Mattress - McKesson	$ 5,044	10	$ 252	
4/10/2015	Bladder Scanner - McKesson	8814	10	441	
6/29/2015	Security Brackets - Karpilow Safe & Lock	1500	10	75	
6/30/2015	Copy Machine Social Services- CBS	6945	3	1158	
8/28/2015	Copy Machine Nurse Station- CBS	6645	3	1108	
Total additions for Movable Equipment		$ 33,507		$ 3,262	*
Deletions:					
Total deletions for Movable Equipment		$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report period

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

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2015	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1. Financing Fees First Niagara	12	2014	15 years	78,468		SL		1,527	
2. Financing Fees Webster	3	11		16,595	3,896			12,699	
3.									
B-4. Subtotal									14,226
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***									14,226

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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CSP-25 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2015	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	10/01/95
2. Date Structure Completed	10/01/95
3. If **NOT** Original Owner, Date of Purchase	10/01/95
4. Date of Initial Licensure	10/01/95
5. Total Licensed Bed Capacity	40
6. Square Footage	29,500
7. Acquisition Cost	
a. Land	
b. Building	764,000

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			
b. Date Mortgage Obtained	12/31/14			
c. Interest Rate for the Cost Year	4.00%			
d. Term of Mortgage (number of years)	15			
e. Amount of Principal Borrowed	800,000			
f. Principal balance outstanding as of _____	758,272			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Leeway, Inc.	2167-C	9/30/2015	26 | 37

Item		Total	CCNH	RHNS	Residential Care Home
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$	48,964	37,983		10,981
Name of Lender: First Niagara	Rate: 50% Variable & 50% SWAP Fixed				
Address of Lender					
2. Second Mortgage	$				
Name of Lender	Rate				
Address of Lender					
3. Third Mortgage	$				
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage	$				
Name of Lender	Rate				
Address of Lender					
B. CHEFA Loan Information					
1. Original Loan Amount	$				
2. Loan Origination Date					
3. Interest Rate %					
4. Term					
5. CHEFA Interest Expense					
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5)	$	48,964	37,983		10,981

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Leeway, Inc.	2167-C	9/30/2015	27 | 37

Item			Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:			48,964	37,983		10,981
12. C. Movable Equipment						
1. Automotive Equipment		$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (*Specify*)		$	431	334		97
A. Item Xerox Copier	Rate Lease	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		$	431	334		97
12. D. Other Interest Expense (*Specify*) Working Capital Loans		$	1,674	1,299		375
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)		$	51,069	39,616		11,453
14. Insurance						
a. Insurance on Property (buildings only)		$	20,564	15,400		5,164
b. Insurance on Automobiles		$				
c. Insurance other than Property (as specified above)						
1. Umbrella (*Blanket Coverage*)		$	22,580	16,910		5,670
2. Fire and Extended Coverage		$				
3. Other (*Specify*) Fid. Bonds, Cyber, D&O, Chrime		$	14,361	10,755		3,606
14d. ***Total Insurance Expenditures (14a + b + c)***		$	57,505	43,065		14,440
15. ***Total All Expenditures (A-13 thru C-14)***		$	5,539,796	4,849,991		689,805

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CSP-28 Rev. 9/2002

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Leeway, Inc.	2167-C	9/30/2015	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
Page 10 - Salaries and Wages							
1.	10		Outpatient Service Costs $				
2.	10		Salaries not related to Resident Care $				
3.	10		Occupational Therapy $				
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.	13		Resident Care Physicians ** $	230	230		
6.	13		Occupational Therapy $	53,896	53,896		
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.	15		Discriminatory Benefits $				
9.	15		Bad Debts $	22,000	16,475		5,525
10.	15		Accounting & Legal $	126	94		32
11.	15		Telephone $				
12.	15		Cellular Telephone $				
13.	15		Life insurance premiums on the life of Owners, Partners, Operators $				
14.	15		Gifts, flowers and coffee shops $				
15.	15		Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.	15		Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.	15		Automobile Expense (e.g. personal use) $				
18.			Unallowable Advertising * $	214	193		21
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $	6,721	6,048		673
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	10,096	10,096		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $	4,192	3,139		1,053
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	97,475	90,171		7,304

* 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
		Subtotal	$ 1,632	$ -	$ -
		Laboratory	$ -	$ -	$ -
		Lab - Medicare	$ 4,232	$ -	$ -
		-	$ -	$ -	$ -
		Subtotal	$ 4,232	$ -	$ -
		Medical Supplies	$ -	$ -	$ -
		-	$ -	$ -	$ -
		Subtotal	$ -	$ -	$ -
		Oxygen (Non Emergency)	$ -	$ -	$ -
		-	$ -	$ -	$ -
		-	$ -	$ -	$ -
		Subtotal	$ -	$ -	$ -
		Occupational Therapy			
		-			
Total Other A&G Adjustments			$ 10,096	$ -	$ -

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CSP-29 Rev. 10/2006

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

Name of Facility	License No.	Report for Year Ended	Page
Leeway, Inc.	2167-C	9/30/2015	29 of 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
			Subtotals Brought Forward $	97,475	90,171		7,304
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs $	44,901	44,901		
28.			Ambulance/Limousine $				
29.			X-rays, etc $	1,632	1,632		
30.			Laboratory $	4,232	4,232		
31.			Medical Supplies $				
32.			Oxygen (non emergency) $				
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $				
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Research or Experimental Activities $				
43.			Radio and Television Revenue $				
44.			Vending Machine Revenue $				
45.			Purchase Discounts and Allowances $				
46.			Duplications of functions or services $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest $				
48.			Interest Income on Accounts Rec $				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule $				
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
51.	***Total Amount of Decrease (Items 1 - 50)*** $			148,240	140,936		7,304

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

Attachment Page 29

Leeway, Inc.
9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Ancillary Costs			$ -	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
15		-	$ -	$ -	$ -
15		-	$ -	$ -	$ -
Total Other Adjustments			$ -	$ -	$ -

Schedule of Unallowable Building Interest

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

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CSP-30 Rev.10/2005

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Leeway, Inc.	2167-C	9/30/2015	30 | 37

Item		Total	CCNH	RHNS	Residential Care Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	5,237,348	4,498,200		739,148
b. Medicaid Room and Board Contractual Allowance **	$	(639,227)	(551,233)		(87,994)
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	220,950	220,950		
b. Medicare Room and Board Contractual Allowance **	$	332,348	332,348		
4. a. Private-Pay Residents and Other	$				
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	59,730	59,730		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(59,730)	(59,730)		
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	$	56,658	56,658		
b. Physical Therapy - Medicare Contractual Allowance **	$	(49,589)	(49,589)		
c. Physical Therapy - Non-Medicare	$	62,207	62,207		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(62,207)	(62,207)		
4. a. Speech Therapy - Medicare	$	19,136	19,136		
b. Speech Therapy - Medicare Contractual Allowance **	$	(16,671)	(16,671)		
c. Speech Therapy - Non-Medicare	$	26,420	26,420		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(26,420)	(26,420)		
5. a. Occupational Therapy - Medicare	$	54,475	54,475		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(45,413)	(45,413)		
c. Occupational Therapy - Non-Medicare	$	62,403	62,403		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(62,403)	(62,403)		
6. a. Other *(Specify)* - Medicare	$	5,422	5,422		
b. Other *(Specify)* - Non-Medicare	$	(5,422)	(5,422)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	5,170,015	4,518,861		651,154
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	4,192	3,139		1,053
2. Rental of rooms to non-residents	$				
3. Telephone	$	868			868
4. Rental of Television and Cable Services	$	2,267			2,267
5. Interest Income *(Specify)*	$	184	138		46
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	67,258	50,367		16,891
V. Total Other Revenue (1 thru 8)	$	74,769	53,644		21,125
VI. Total All Revenue (III +V)	$	5,244,784	4,572,505		672,279

* *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
	Lab Rev - Medicare Replace	$ 835		
	Lab- Medicare	$ 4,587		
Total Other Resident Revenue - Medicare		$ 5,422	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
	Medicare Part A Allowance Reclass	$ (4,587)		
	Medicare Replace Allowance Reclass	$ (835)		
Total Other Resident Revenue		$ (5,422)	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	Residential Care Home
	Interest Income		$ 138	$ -	$ 46
Total Interest Income			$ 138	$ -	$ 46

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
	Misc. Revenue	$ 59	$ -	$ 20
	DOH Grant	$ -	$ -	$ -
	Fund Raiser-Annual Appeal	$ 2,966	$ -	$ 994
	Donations - Unrestricted	$ 24,774	$ -	$ 8,308
	Golf Outing Revenue	$ 1,213	$ -	$ 407
	Restricted Donations - Rec De	$ 187	$ -	$ 63
	Donations - United Way	$ 745	$ -	$ 250
	Brick Campaign	$ 15,307	$ -	$ 5,133
	Whiffenpoof Concert	$ 5,116	$ -	$ 1,716
	-			
Total Other Revenue		$ 50,367	$ -	$ 16,891

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2015	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 212,937
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 570,753
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 82,272
4 Inventories				$
5. Prepaid Expenses				$ 26,317
a. Prepaid Insurance		21,702		
b. Prepaid Dues		888		
c. Prepaid-DSS Case Mgmt Expenses		3,727		
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 892,279
B. Fixed Assets				
1. Land				$ 211,448
2. Land Improvements	*Historical Cost	133,720		$ 106,179
	Accum. Depreciation	27,541	Net	
3. Buildings	*Historical Cost	4,654,305		$ 2,006,888
	Accum. Depreciation	2,647,417	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	215,598		$ 125,810
	Accum. Depreciation	89,788	Net	
6. Movable Equipment	*Historical Cost	766,733		$ 252,596
	Accum. Depreciation	514,137	Net	
7. Motor Vehicles	*Historical Cost	24,957		$
	Accum. Depreciation	24,957	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 5,449,027
Assets (Net of Deprec) - Non Reimbursable		222,046		
CIP - RCH Expansion		5,226,981		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 8,151,948

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2015	32	37

Account				Amount
			Total Brought Forward:	$ 9,044,227
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 77,941
Deferred Financing FN Mortg		20,361		
Deferred Financing FN Construc		59,107		
Acc Amortz - FN Mortgage		(1,527)		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 77,941
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 9,122,168

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2015	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 1,210,884
	2. Notes Payable (*itemize*)				$ 2,145
	Note Payable - Insurance		2,145		
	3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
	Name of Lender	Purpose	Amount	Date Due	
	4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 81,455
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 2,122
	7. Medicare Final Settlement Payable				$
	8. Medicare Current Financing Payable				$
	9. Mortgage Payable (*Current Portion*)				$
	10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
	11. Accrued Income Taxes*				$
	12. Other Current Liabilities (*itemize*)				$ 68,654
			Resident Trust Fund	4,892	
	Advance Bill				
	Accrued Provider Tax	52,886			
	Deferred Income-DMHAS	10,876			
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 1,365,260

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2015	34	37

Account	Amount
Total Brought Forward:	1,365,260
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$ 773,297
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)		$ 4,540,399
DSS Bond Advances	2,850,000	
Construction Loan-First Niagar	1,505,060	
Construction Loan Swap Liab	185,339	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 5,313,696
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 6,678,956

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

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2015	35	37

Account	Amount
A. **Reserves**	
1. Reserve for value of leased land	$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
3. Reserve for depreciation value of leased personal property (*Equity)*	$
4. Reserve for leasehold real properties on which fair rental value is based	$
5. Reserve for funds set aside as donor restricted	$
6. Total Reserves	$
B. **Net Worth**	
1. Owner's Capital	$
2. Capital Stock	$
3. Paid-in Surplus	$
4. Treasury Stock	$
5. Cumulated Earnings	$ 2,840,852
6. Gain or Loss for Period 10/1/2014 thru 9/30/2015	$ (397,640)
7. Total Net Worth	$ 2,443,212
C. ***Total Reserves and Net Worth***	$ 2,443,212
D. ***Total Liabilities, Reserves, and Net Worth***	$ 9,122,168

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2015	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2014			$ 2,840,839
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 5,846,873
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 6,244,513
D.	Net Income or Deficit			$ (397,640)
E.	Balance			$ 2,443,199
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
	Rounding			3
F-3.	Total Additions			$ 3
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period***	09/30/15		$ 2,443,202

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-37 Rev. 9/2002

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc.	2167-C	9/30/2015	37	37

Check appropriate category

HIV AIDS		
☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☑ Residential Care Home

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
	CFO	2/15/2016

Printed Name of Preparer	
Robert Morgan	
Addres Address	Phone Number
40 Albert Street, New Haven, CT 06511	203 865-0068

Level	Item	Reported as