State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2016

Name of Facility (as licensed) CH - Crossings West, LLC d/b/a Crossings West Health and Rehabilitation Center		
Address (No. & Street, City, State, Zip Code) 89 Viets Street, New London, CT 06320-3355		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2015	Report for Year Ending 10/4/2016	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2393			07-5267

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	0000010546		

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 CH - Crossings West, LLC d/b/a Crossings West Health and Rehabilitation Center [facility name], for the cost report period beginning October 1, 2015 and ending October 4, 2016, 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. **{a}**

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.

{a} Subject to Desk Audit Review

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Kimberly Carlson			Printed Name (Owner) Alan Silverman	
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 CH - Crossings West, LLC d/b/a Crossings West Health and Rehabilitation Center	Period Covered:	From 10/1/2015	To 10/4/2016
Address of Facility 89 Viets Street, New London, CT 06320-3355			
Report Prepared By Marcum LLP	Phone Number 203-781-9600	Date 2/2/2017	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-447-1471	10/4/2016	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
CH - Crossings West, LLC d/b/a Crossings West Health and R	89 Viets Street, New London, CT 06320-3355

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	2393			07-5267

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

DSS approved the filing period of 10/1/2015 - 10/4/2016 due to a change of ownership.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
Kimberly Carlson		002018

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

Name	License No.:
N/A	

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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

Name of Partners/Members	Business Address	Title	% Owned
N/A			

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
CH - Crossings West, LLC d/b/a Crossings W	2393	10/4/2016	3A	37

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

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Chestnust Health and Rehabilitation Group, Inc.	5 Morgan Highway, Suite 6 Scranton, PA 18508	DE

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Alan Silverman	5 Morgan Highway, Suite 6 Scranton, PA 18508	Officer/Director	
Allen Brecht	3001 Honeymead Road, Downington, PA 19335	Director	
Louise Seifert	1401 Skokie Road #83H, Seal Beach, CA 90740	Director	
Names of Stockholders Owning at Least 10% of Shares			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
CH - Crossings West, LLC d/b/a Crossings West H	2393	10/4/2016	3B	37

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.

N/A

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.

Name of Facility	License No.	Report for Year Ended	Page	of
CH - Crossings West, LLC d/b/a Crossings West Health and	2393	10/4/2016	6	37

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
Mail Finance, 478 Wheelers Farms Rd, Milford, CT 06461	○	◉	Mail Protect	11/17/14	Monthly as Needed	263	263
Ricoh, 70 Valley Stream Parkway, Malvern, PA 19355	○	◉	Printer	10/04/14	Monthly as Needed	581	581
ACPL A Hanger Company, 4850 Joule Street, Suite A1, Reno, NV 89502	○	◉	Clinical Starter Install Kit (M1 Kit), Omni Sound Lease	06/01/15	Monthly as Needed	12,017	12,017
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ○ No **Total ***** 12,861

* 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 Moore, Stephens & Lovelace CPAs	311 Park Place Boulevard Suite 100, Clearwater, FL 33759
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Financial Audit & Health Care Consulting (Disallowed $7,182 of PY Expenses on Pg. 28)	$ 7,981
2		$
3		$
4		$
	Charge for Services Provided	$ 7,981

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

⊙ Yes ○ No Page 15, Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Capital Source	
2 DLA Piper LLC	215-656-3300
3 Doran Derwent, PLLC	616-451-8690
4 Faegre Baker Daniels LLP	317-237-0300
5 See Attachment Pg. 7a	See Attachment Pg. 7a

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

1
2 One Liberty Place,1650 Market St., Ste4900,Philadelphia,PA19103
3 5960 Tahoe Dr,SE,Suite 101, Grand Rapids, MI 49546
4 300 N. Meridian Street, Ste 2700,Indianapolis, IN 46204
5 See Attachment Pg. 7a

Services Provided by This Firm (*describe fully*)

1	Line of Credit (Disallowed on Pg. 28)	$ 123
2	Chestnut Acquisition (Disallowed on Pg. 28)	$ 3,068
3	Chestnut Acquisition (Disallowed on Pg. 28)	$ 5,292
4	Chestnut Acquisition (Disallowed on Pg. 28)	$ 7,447
5	See Attachment Pg. 7a (Disallowed $221 on Pg. 28)	$ 732
	Charge for Services Provided	$ 16,662

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

⊙ Yes ○ No Page 15, Line 1e

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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 (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	66	66			66	66			66	66		
B. On last day of THIS report period	66	66			66	66			66	66		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	46	46			46	46			46	46		
B. As of midnight of THIS report period	47	47			46	46			47	47		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,987	1,987			1,390	1,390			597	597		
B. Medicaid (Conn.)	16,713	16,713			10,468	10,468			6,245	6,245		
C. Medicaid (other states)												
D. Private Pay	539	539			342	342			197	197		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	19,239	19,239			12,200	12,200			7,039	7,039		
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)**	19,239	19,239			12,200	12,200			7,039	7,039		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
CH - Crossings West, LLC d/b/a Crossings W	2393	10/4/2016	9	37

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

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

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

Change in Resident Days	CCNH	RHNS	(Specify)
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	(Specify)	R.C.H.	ICF-MR
No. of Residents	6	39		2				
Per Diem Rate								
a. One bed rm.	Various	192.23		437.00				
b. Two bed rms.	Various	192.23		370.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	1,858	1,858		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,160	1,160		
2. Restorative Treatments				
C. Other	3,342	3,342		
D. ***Total Physical Therapy Treatments***	6,360	6,360		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	730	730		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	3	3		
2. Restorative Treatments				
C. Other	282	282		
D. ***Total Speech Therapy Treatments***	1,015	1,015		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	2,086	2,086		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,024	1,024		
2. Restorative Treatments				
C. Other	6,114	6,114		
D. ***Total Occupational Therapy Treatments***	9,224	9,224		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
CH - Crossings West, LLC d/b/a Crossings West Health and	2393	10/4/2016	10	37

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	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)	115,958	2,224				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	161,664	5,913				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	41,463	1,646				
c. Dietary Workers	127,361	10,043				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	36,055	1,502				
b. Other Maintenance Workers	9,308	617				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	101,048	2,056				
b. RN						
1. Direct Care	346,236	9,494				
2. Administrative**	110,157	3,237				
c. LPN						
1. Direct Care	336,274	11,983				
2. Administrative**						
d. Aides and Attendants	499,526	37,369				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	40,565	2,834				
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	42,225	1,256				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	1,967,840	90,174				

* 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		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
	-					
Total	$ -	-	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
	-					
IV Consultant	$ 5,410	Monthly Fee				
Clinical Nurse Consulting	$ 28,915	Contract				
Total	$ 34,325	-	$ -	-	$ -	-

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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	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
CH - Crossings West, LLC d/b/a Crossings West Health and Rehabilit	2393	10/4/2016	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Dane Walton (10/1/2015 - 4/1/2016)	57,666			Non Discrim	Administrator	1,106	A2			
Kimberly Carlson (4/2/2016 - Present)	58,292			Non Discrim	Administrator	1,118	A2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
CH - Crossings West, LLC d/b/a Crossings West He	2393	10/4/2016	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	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	330	Monthly Fee				
3. Pharmacist	6,070	Monthly Fee				
4. Podiatrist	115	Fee Based				
5. Physical Therapy						
a. Resident Care	158,901	2,087				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	31,161	Monthly Fee				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	30,358	273				
b. Other						
10. Occupational Therapist						
a. Resident Care	178,488	2,532				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	1,742	42				
2. Administrative***						
b. LPN						
1. Direct Care	5,225	352				
2. Administrative***						
c. Aides	90	8				
d. Other						
12. Other (Specify)						
See Attached Schedule	34,325					
B-13 Total Fees Paid in Lieu of Salaries	446,805	5,294				

* 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
CH - Crossings West, LLC d/b/a Crossings West Health	2393	10/4/2016	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
LTC MANAGEMENT, 174 SCOTT RD , PROSPECT, CT 06712	Dentist	○	⊙	N/A
Consulting Support Services, LLC, 1665 Palm Beach Lakes Blvd, Suite 400, West Palm Beach	Pharmacy Liaison	○	⊙	N/A
LTCPCMS, Inc., 9962 Brook Road, #601, Glen Allen, VA 23059	Pharmacy Consultant	○	⊙	N/A
Pharmerica, P.O. Box 409251, Atlanta, GA 30384-9251	Pharmacy & IV Consultant	○	⊙	N/A
Accomplish Therapy, LLC, 1675 Palm Beach Lakes Blvd, Suite 900, West Palm Beach FL	Physical, Occupational & Speech Therapy	○	⊙	N/A
SELECT MEDICAL REHABILITATION SERVICES, P.O. BOX 643920,	Physical, Occupational & Speech Therapy	○	⊙	N/A
ENCORE REHAB SERVICES, P.O. BOX 643920, PITTSBURGH,PA 15264	Physical, Occupational & Speech Therapy	○	⊙	N/A
QUALITY REHABILITATION SERVICES, LLC, 30 MANMAR DRIVE SUITE 9, PLAINVILLE,	Physical, Occupational & Speech Therapy	○	⊙	N/A
Dr. Donovan IPC Hospitalists of New England	Medical Director	○	⊙	N/A
Dr. Sarosi IPC Hospitalists of New England	Medical Director	○	⊙	N/A
IPC HEALTHCARE INC, P.O. BOX 844929, LOS ANGELES,CA 90084-4929	Medical Director	○	⊙	N/A
READYNURSE STAFFING SERVICES C/O READYNURSE STAFFING, P.O. BOX 301076,	LPNs	○	⊙	N/A
The Nurse Network, 653 Main Street, Plantsville, CT 06479	RNs & LPNs	○	⊙	N/A
VERA NICHOLS, 28 LAUREL DRIVE, WILLINGTON,CT 06279	CNAs	○	⊙	N/A
BARRIEYE CARE CENTER, 489 ROUTE 184 SUITE 100, GROTON, CT 06340-6227	Optometry	○	⊙	N/A
Hybris Health Services, LLC, 200 Kendall St, Springfield, MA	Clinical Nurse Consulting	○	⊙	N/A
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
CH - Crossings West, LLC d/b/a Crossings West	2393	10/4/2016	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	64,756	64,756		
2. Disability Insurance	$	(28)	(28)		
3. Unemployment Insurance	$	52,484	52,484		
4. Social Security (F.I.C.A.)	$	149,503	149,503		
5. Health Insurance	$	68,120	68,120		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	734	734		
7. Pensions (Non-Discriminatory)	$				
(not-owners and not-operators)					
8. Uniform Allowance	$	(159)	(159)		
9. Other (*Specify*)	$	7,175	7,175		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	90,239	90,239		
d. Accounting and Auditing	$	7,981	7,981		
e. Legal (*Services should be fully described on Page 7)*	$	16,662	16,662		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	11,369	11,369		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	18,826	18,826		
2. Cellular Phones	$	4,695	4,695		
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*)	$	231	231		
See Attached Schedule					
3. Resident Day User Fee	$	306,598	306,598		
Subtotal	$	799,186	799,186		

* 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**

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
	-		
Emp Ben - Other	$ 847		
Emp Ben - Empl Hlth & Welfare	$ 3,068		
Emp Ben - 401(K)-Company Cntrb	$ 377		
Emp Ben - Empl Sfty Prog Prem	$ 1,341		
Emp Ben - Tuition Reimb	$ 97		
Emp Ben - Employee Background Chk	$ 232		
Emp Ben - Employee Drug Screen	$ 1,213		
Total	$ 7,175	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
	-		
Sales & Use Tax	$ 231		
Total	$ 231	$ -	$ -

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
CH - Crossings West, LLC d/b/a Crossings West Hea	2393	10/4/2016	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		799,186	799,186		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	459	459		
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	3,115	3,115		
5. Education Expenses Related to Seminars and Conventions	$				
6. Automobile Expense (*not purchase or depreciation*)	$	5,553	5,553		
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	4,013	4,013		
2. Advertising Telephone Directory (*all such expenses*)***	$	2,271	2,271		
3. Advertising Other (*Specify*)***	$	641	641		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	3,048	3,048		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	4,855	4,855		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	786	786		
9. Subscriptions	$	2,296	2,296		
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	73,633	73,633		
12. Administrative Management Services**	$	159,346	159,346		
13. Other (*Specify*) See Attached Schedule	$	23,226	23,226		
C-14 Total Administrative & General Expenditures	$	1,082,428	1,082,428		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
	-		
Supp - Marketing	$ 126		
Advert - Promotional	$ 250		
Advert - Other	$ 253		
Advert - Public Relations	$ 12		
Total Other Advertising	$ 641	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
	-		
CT Association of Health Care Facilities	$ 4,855		
Total Dues	$ 4,855	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
	-		
Storage Fees	$ 2,103		
Misc. - Employees	$ 22		
Professional Fees Consultant	$ 6,013		
Professional Fees - Insurance Consultant	$ 179		
Internet Services	$ 1,145		
Licenses & Permits	$ 1,215		
Bank Service Charges	$ 1,340		
NAC - Fines & Penalties	$ 7,051		
Fin Charges - Unused Line Fees	$ 4,158		
Total Other Administrative and General	$ 23,226	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
CH - Crossings West, LLC d/b/a Crossing	2393	10/4/2016	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 #
Kane Financial Services, LLC	30,267	Financial Oversight	Page 16 / Line m12
Hybris Health Services, LLC	1,352	Operational Oversight	Page 16 / Line m12
Hybris Health Services, LLC	28,915	Clinical Nurse Consulting	Page 13 / Line B12
Wachusett Ventures	127,727	Management Company	Page 16 / Line m12

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

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CSP-18 Rev. 9/2002

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
CH - Crossings West, LLC d/b/a Crossings West Healt	2393	10/4/2016	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	66,844	66,844		
2. Non-Food Supplies	$	15,378	15,378		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	23,190	23,190		
c. Management Services**	$				
d. Other (*Specify*)_____ Minor Equipment & Software	$	5,151	5,151		
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	110,563	110,563		

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

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
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.
L.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
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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CSP-19 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page of
CH - Crossings West, LLC d/b/a Crossings West Health	2393	10/4/2016	19 | 37

Item		Total	CCNH	RHNS	(Specify)
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. $	205	205		
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)*	$	69,824	69,824		
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	70,029	70,029		

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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CSP-20 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
CH - Crossings West, LLC d/b/a Crossings Wes	2393	10/4/2016	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$				
b. Purchased Services (*by contract other than through Management Services*)	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$	105,121	105,121		
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	105,121	105,121		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Pharmerica		$	107,581	107,581		
b. Medicine Cabinet Drugs		$	5,923	5,923		
c. Medical and Therapeutic Supplies		$	21,509	21,509		
d. Ambulance/Limousine***		$	(8,323)	(8,323)		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	2,413	2,413		
f. X-rays and Related Radiological Procedures***		$	3,197	3,197		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	7,433	7,433		
i. Recreation		$	7,509	7,509		
j. Other (Specify)**** See Attached Schedule		$	69,439	69,439		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	216,681	216,681		

* 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	(Specify)
	-		
Food Purch - Tube Feeding	$ 939		
Supp - Universal Precaution	$ 4,018		
Supp - Wound Care	$ 6,784		
Supp - Prosthetic Device	$ 554		
Supp - Respiratory Supplies	$ 3,484		
Supp - IV	$ 2,440		
Supp - Phys Therapy	$ 1,324		
Supp - Occup Therapy	$ 80		
Supp - Routine Hygiene	$ 2,829		
Supp - Incontinent Supplies	$ 16,252		
Respiratory Equipment Rental	$ 18,414		
Bariatric Equipment Rental	$ 404		
Wound Vacs Equipment Rental	$ 8,519		
Air Mattresses Rentals	$ 490		
Alt Press Air Mattress Rentals	$ 1,311		
Wheelchairs Rentals	$ 636		
IV Pump Equipment Rental	$ 192		
Occupational Therapy Equipment	$ 274		
Nursing Equipment Purchase	$ 16		
Physical Therapy Equipment Purchase	$ 110		
Occupational Therapy Equipment Purchase	$ 94		
Patient Medical Expense (Non-allowable)	$ 56		
Replace of Res. Personal Prop.	$ 219		
Total Other Resident Care	$ 69,439	$ -	$ -

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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
CH - Crossings West, LLC d/b/a Crossings West Health and Rehabilitation (	2393	10/4/2016	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Consulting Support Services, LLC	Blvd, Suite 400, West Palm Beach FL 33401	○	⊙	N/A	A/R supp, risk mgmt, recruitment, business	14,952			16	m11
L&L Contract Services	11310 Wiles Road, Coral Springs, FL 33076	○	⊙	N/A	Laundry Services	28,225			19	3b
Healthcare Services Group	300, Bensalem, PA 19020	○	⊙	N/A	Housekeeping Services	105,121			20	4b
Healthcare Services Group	300, Bensalem, PA 19020	○	⊙	N/A	Laundry Services	41,599			19	3b
Professional Grounds Maintenance, Inc	P.O. Box 231, Quaker Hill, CT 06375	○	⊙	N/A	Landscaping	12,807			22	6f
Facility Support Company, LLC	Blvd, West Palm Beach, FL 33401	○	⊙	N/A	IT Support	16,411			16	m11
CWPM, LLC	P.O. Box 415, Plainville CT 06062	○	⊙	N/A	Garbage Removal	14,223			22	6f
VCPI	111 W Michigan St, Milwaukee, WI 53203	○	⊙	N/A	IT Support	16,888			16	m11
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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
CH - Crossings West, LLC d/b/a Crossings W	2393	10/4/2016	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	6,318	6,318		
b. Heat	$	6,400	6,400		
c. Light & Power	$	96,795	96,795		
d. Water	$	22,578	22,578		
e. Equipment Lease (*Provide detail on page 6*)	$	12,861	12,861		
f. Other (*itemize*)	$	67,569	67,569		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	212,521	212,521		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	55,286	55,286		
c. Non-Movable Equipment	$				
d. Movable Equipment	$	19,098	19,098		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	74,384	74,384		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$	3,108	3,108		
b. Mortgage Expense	$				
c. Leasehold Improvements	$	531	531		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	3,639	3,639		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	526,363	526,363		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	42,430	42,430		
c. Personal property taxes	$	5,669	5,669		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	652,485	652,485		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
	-		
Consulting Support	$ 1,323		
Supplies - Maintenance	$ 14,057		
Minor Equipment Purchase	$ 2,111		
Environmental Site Assessment	$ 970		
R&M - Building	$ 11,198		
R&M - Security	$ 324		
R&M - Garbage	$ 14,443		
R&M - Hazardous Waste	$ 513		
R&M - Maintenance Contracts	$ 22,630		
Total Other Repairs and Maintenance	$ 67,569	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
CH - Crossings West, LLC d/b/a Crossings West Health and Rehabilita	2393	10/4/2016	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								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period	311,789		311,789	5,526	S/L	Various	28,129	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	307,738		307,738		S/L	Various	27,157	
B-4. Subtotal								55,286
C. **Non-Movable Equipment**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			Var	Var	71,284		71,284	6,441	S/L	Various	8,318	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			Var	Var	104,826		104,826		S/L	Various	10,780	
D-3. Subtotal												19,098
E. ***Total Depreciation***												74,384

CH - Crossings West, LLC d/b/a Crossings West Health and Rehabilitation Center
10/4/2016

Schedule of Land Improvements Acquired during this report period

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

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

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

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
9/30/2016	Doors/Door Hardware	$ 2,240	15	$ 151	
9/30/2016	Ceilings	11	20	1	
9/30/2016	Plumbing	1,950	20	99	
9/30/2016	Electrical Generator	38,509	5	7,786	
9/30/2016	Exterior Repair	1,655	20	84	
9/30/2016	Paint	85,655	10	8,659	
9/30/2016	Millwork	17,542	20	887	
9/30/2016	Roof Top Units	730	20	37	
9/30/2016	Hand Rail/ Corner Guards	233	20	12	
9/30/2016	General Conditions	8,237	20	416	
9/30/2016	Flooring	70,817	15	4,773	
9/30/2016	CO # 2 Additional Flooring Work	11,879	15	801	
9/30/2016	CO # 3 Engineering Door	750	20	38	
9/30/2016	CO # 4 Engineering POC Wall	1,500	20	76	
9/30/2016	CO # 5 PT Restroom Engineer Stamped Drawings	4,000	20	202	
9/30/2016	CO # 7 Admin Area Engineer Stamped Drawings	500	20	25	
9/30/2016	SL Fee 18%	61,530	20	3,110	
Total additions for Building Improvements		$ 307,738		$ 27,157	*
Deletions:					
Total deletions for Building Improvements		$ -		$ -	**

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

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

Schedule of Non-Movable Equipment Acquired during this report period

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/31/2015	HP Mobil thin client	$ 774	3	$ 261	
9/30/2016	FF&E	55,559	10	5,617	
9/30/2016	Soft Goods	42,270	10	4,273	
9/30/2016	CO # 1 Dressers Add	6,223	10	629	
Total additions for Movable Equipment		$ 104,826		$ 10,780	*
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
CH - Crossings West, LLC d/b/a Crossings West Health and	2393	10/4/2016	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	2	15	10 Years	5,250	525	S/L		531	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									531
D. ***Total Amortization***									531

* 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
CH - Crossings West, LLC d/b/a Cross	2393	10/4/2016	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	66
6. Square Footage	21,158
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)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				
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
Care Capital Properties, 353 North Clark Suite 2900, Chicago, IL 60654	Building & Equipment	03/19/14	15	526,363

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
CH - Crossings West, LLC d/b/a Cros	2393	10/4/2016	26 | 37

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

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
CH - Crossings West, LLC d/b/a Cr	2393	10/4/2016	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				
12. C. Movable Equipment				
1. Automotive Equipment $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
2. Other (*Specify*) $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
B. Item / Rate / Amount				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $				
12. D. Other Interest Expense (*Specify*) $	16,119	16,119		
Line of Credit & Notes Payable Interest				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	16,119	16,119		
14. Insurance				
a. Insurance on Property (buildings only) $	11,487	11,487		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	52,069	52,069		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $	3,279	3,279		
D & O, Cyber, Hired/Non Auto				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	66,835	66,835		
15. ***Total All Expenditures (A-13 thru C-14)*** $	4,947,427	4,947,427		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
CH - Crossings West, LLC d/b/a Crossings West Health and Re	2393	10/4/2016	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	B10a	Occupational Therapy $	178,488	178,488		
7.			Other - See attached Schedule $	5,525	5,525		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	90,239	90,239		
10.	15	1d/e	Accounting & Legal $	23,333	23,333		
11.			Telephone $				
12.	15	1h2	Cellular Telephone $	3,603	3,603		
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.	15	1a9	Education expenditures to colleges or universities for tuition and related costs for owners and employees $	97	97		
16.	16	L4	Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $	336	336		
17.			Automobile Expense (e.g. personal use) $				
18.	16	m2/3	Unallowable Advertising * $	2,912	2,912		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.	16	m12	Unallowable Management Fees $	26,358	26,358		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	16,891	16,891		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $				
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) $	347,782	347,782		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Salaries Adjustment			$ -	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B4	Podiatrist	$ 115		
13	B12	IV Consultant	$ 5,410		
Total Other Fees Adjustments			$ 5,525	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
15	1a9	Emp Ben - Other	$ 847		
15	1g	Marketing Supplies	$ 3,489		
16	m8a	Chamber of Commerce Dues	$ 786		
16	m13	Misc. Employees	$ 22		
16	m13	Non-Allowable Bank Services Charges	$ 538		
16	m13	NAC - Fines & Penalties	$ 7,051		
16	m13	Fin Charges - Unused Line Fees	$ 4,158		
Total Other A&G Adjustments			$ 16,891	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
CH - Crossings West, LLC d/b/a Crossings West Health and	2393	10/4/2016	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	347,782	347,782		
Page 20 - Resident Care Supplies***							
27.	20	5a1/2	Prescription Drugs $	107,581	107,581		
28.	20	5d	Ambulance/Limousine $	(8,323)	(8,323)		
29.	20	5f	X-rays, etc $	3,197	3,197		
30.	20	5h	Laboratory $	7,433	7,433		
31.			Medical Supplies $				
32.	20	5e2	Oxygen (non emergency) $	2,413	2,413		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	45,608	45,608		
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 $	3,108	3,108		
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 $	1,098	1,098		
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)*** $	509,897	509,897		

*** 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

CH - Crossings West, LLC d/b/a Crossings West Health and Rehabilitation Center
10/4/2016

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5i	Cable Television Disallowance (See Attached)	$ 1,354		
20	5j	Food Purch - Tube Feeding	$ 939		
20	5j	Supp - Wound Care	$ 6,784		
20	5j	Supp - Prosthetic Device	$ 554		
20	5j	Supp - Respiratory Supplies	$ 3,484		
20	5j	Supp - IV	$ 2,440		
20	5j	Supp - Occup Therapy	$ 80		
20	5j	Respiratory Equipment Rental	$ 18,414		
20	5j	Bariatric Equipment Rental	$ 404		
20	5j	Wound Vacs Equipment Rental	$ 8,519		
20	5j	Air Mattress Rental	$ 490		
20	5j	Alt Press Air Mattress	$ 1,311		
20	5j	IV Pump Equipment Rental	$ 192		
20	5j	Occupational Therapy Equipment	$ 274		
20	5j	Occupational Therapy Equipment Purchase	$ 94		
20	5j	Patient Medical Expense	$ 56		
20	5j	Replace of Res. Personal Prop.	$ 219		
Total Other Ancillary Costs			$ 45,608	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	8a	Amort - Def Finance Costs	$ 3,108		
Total Other Property Adjustments			$ 3,108	$ -	$ -

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30	IV 8	Rebate Revenue	$ 1,098		
Total Other Adjustments			$ 1,098	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
CH - Crossings West, LLC d/b/a Crossing	2393	10/4/2016	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	4,021,709	4,021,709		
b. Medicaid Room and Board Contractual Allowance **	$	(1,440,517)	(1,440,517)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	864,100	864,100		
b. Medicare Room and Board Contractual Allowance **	$	106,910	106,910		
4. a. Private-Pay Residents and Other	$	260,505	260,505		
b. Private-Pay Room and Board Contractual Allowance **	$	(28,270)	(28,270)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	56,430	56,430		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(120,947)	(120,947)		
c. Prescription Drugs - Non-Medicare	$	24,850	24,850		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(15,186)	(15,186)		
2. a. Medical Supplies - Medicare	$	385	385		
b. Medical Supplies - Medicare Contractual Allowance **	$	(385)	(385)		
c. Medical Supplies - Non-Medicare	$	192	192		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(192)	(192)		
3. a. Physical Therapy - Medicare	$	241,082	241,082		
b. Physical Therapy - Medicare Contractual Allowance **	$	(112,193)	(112,193)		
c. Physical Therapy - Non-Medicare	$	76,644	76,644		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(64,947)	(64,947)		
4. a. Speech Therapy - Medicare	$	47,358	47,358		
b. Speech Therapy - Medicare Contractual Allowance **	$	(17,375)	(17,375)		
c. Speech Therapy - Non-Medicare	$	14,872	14,872		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(10,979)	(10,979)		
5. a. Occupational Therapy - Medicare	$	311,960	311,960		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(209,524)	(209,524)		
c. Occupational Therapy - Non-Medicare	$	75,324	75,324		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(65,689)	(65,689)		
6. a. Other *(Specify)* - Medicare	$	(3,298)	(3,298)		
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	4,012,819	4,012,819		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	55,517	55,517		
V. Total Other Revenue (1 thru 8)	$	55,517	55,517		
VI. Total All Revenue (III +V)	$	4,068,336	4,068,336		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
		-		
30 II 6a	Oxygen - Medicare A	$ 713		
30 II 6a	Oxygen C/A - Medicare A	$ (713)		
30 II 6a	Lab - Medicare A	$ 51,207		
30 II 6a	Lab - C/A - Medicare A	$ (51,207)		
30 II 6a	X-Ray - Medicare A	$ 2,565		
30 II 6a	X-Raye - C/A - Medicare A	$ (2,565)		
30 II 6a	IV Charges - Medicare A	$ 20,318		
30 II 6a	IV Charges C/A - Medicare A	$ (20,318)		
30 II 6a	Medicare B - Sequestration	$ (3,298)		
Total Other Resident Revenue - Medicare		$ (3,298)	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
		-		
30 II 6b	Oxygen - Medicaid	$ 298		
30 II 6b	Oxygen - Hospice	$ 51		
30 II 6b	Oxygen - C/A Medicaid	$ (304)		
30 II 6b	Oxygen - C/A Hospice	$ (45)		
30 II 6b	Infus Ther - Medicaid	$ 594		
30 II 6b	Infus Ther - C/A - Medicaid	$ (594)		
30 II 6b	Lab - Medicaid	$ 2,154		
30 II 6b	Lab - HMO	$ 3,770		
30 II 6b	Lab - Comm Ins	$ 2,733		
30 II 6b	Lab - C/A - Medicaid	$ (2,154)		
30 II 6b	Lab - C/A - HMO	$ (3,770)		
30 II 6b	Lab - C/A - Comm Ins	$ (2,733)		
30 II 6b	X-Ray - Medicaid	$ 293		
30 II 6b	X-Ray - Comm Ins	$ (111)		
30 II 6b	X-Ray - C/A - Medicaid	$ (293)		
30 II 6b	X-Ray - C/A - Comm Ins	$ 111		
30 II 6b	IV Charges - HMO	$ 1,166		
30 II 6b	IV Charges - Comm Ins	$ 41		
30 II 6b	IV Charges - C/A - HMO	$ (1,166)		
30 II 6b	IV Charges - C/A - Comm Ins	$ (41)		
Total Other Resident Revenue		$ -	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
			-		
Total Interest Income			$ -	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
		-		
30 IV 8	Patient Refunds	$ (2,827)		
30 IV 8	Rebate Revenue	$ 1,098		
30 IV 8	Frontline Unrestricted Donation Revenue	$ 57,246		
Total Other Revenue		$ 55,517	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
CH - Crossings West, LLC d/b/a Crossi	2393	10/4/2016	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ (9,297)
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 515,011
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$
a.				
b.				
c.				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 7,308
Exchange		7,308		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 513,022
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost			$
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	5,250		$ 4,194
	Accum. Depreciation	1,056	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	22,423		$ 15,596
	Accum. Depreciation	6,827	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ (2,080)
PPE - Capital Asset Clearing		17,710		
F/S vs C/R NBV		(19,790)		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 17,710

* 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
CH - Crossings West, LLC d/b/a Crossi	2393	10/4/2016	32	37

Account				Amount
		Total Brought Forward:	$	530,732
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			$	
2. Land Improvements	*Historical Cost			
	Accum. Depreciation	Net	$	
3. Buildings	*Historical Cost	619,527		
	Accum. Depreciation	60,812 Net	$	558,715
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation	Net	$	
5. Movable Equipment	*Historical Cost	153,687		
	Accum. Depreciation	18,712 Net	$	134,975
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation	Net	$	
7. Minor Equipment-Not Depreciable			$	
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)			$	693,690
D. Investment and Other Assets				
1. Deferred Deposits			$	3,510
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*)			$	102,475
Due from Wachusett Ventures		102,475		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)			$	105,985
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$	1,330,407

* 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
CH - Crossings West, LLC d/b/a Crossings W	2393	10/4/2016	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 355,040
2. Notes Payable (*itemize*)					$
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*)					$ 29,913
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$
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*)					$ 88,050
Accured Provider Tax	76,200				
Accrued Expenses	11,850				
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 473,003

* 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
CH - Crossings West, LLC d/b/a Crossings	2393	10/4/2016	34	37

Account	Amount
Total Brought Forward:	473,003
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

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

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)		$ 632,603
N/P - CCP	632,603	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 632,603
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 1,105,606

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

Name of Facility	License No.	Report for Year Ended	Page	of
CH - Crossings West, LLC d/b/a Cross	2393	10/4/2016	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	$ 693,690
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$ 693,690
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 336,948
	6. Gain or Loss for Period 10/1/2015 thru 10/4/2016	$ (805,837)
	7. Total Net Worth	$ (468,889)
C.	***Total Reserves and Net Worth***	$ 224,801
D.	***Total Liabilities, Reserves, and Net Worth***	$ 1,330,407

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
CH - Crossings West, LLC d/b/a Crossin	2393	10/4/2016	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2015			$ (1,196,252)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 4,068,336
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 4,874,173
D.	Net Income or Deficit			$ (805,837)
E.	Balance			$ (2,002,089)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Page 27 Expenses $4,947,427			
	F/S vs C/R Depreciation (73,254)			
	Expenses Per F/S $4,874,173			
	2. Other (*itemize*)			
	Due to Change in Mgmt Company 1,533,200			
F-3.	Total Additions			$ 1,533,200
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*** 10/04/16			$ (468,889)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
CH - Crossings West, LLC d/b/a	2393	10/4/2016	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer	
Matthew S. Bavolack	
Addres Address	Phone Number
555 Long Wharf Drive, New Haven, CT 06511	203-781-9600

Subject to the attached accountants' consulting report

Level	Item	Reported as