State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2016

Name of Facility (as licensed) Ledgecrest Health Care Center		
Address (No. & Street, City, State, Zip Code) 154 Kensington Rd. Kensington, CT 06037		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016	

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	220468		

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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Ledgecrest Health Care Center	2046-C	9/30/2016	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Ledgecrest Health Care Center [facility name], for the cost report period beginning October 1, 2015 and ending September 30, 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.

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) David Desell			Printed Name (Owner) Brian J. Foley	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Ledgecrest Health Care Center	Period Covered:		From 10/1/2015	To 9/30/2016
Address of Facility 154 Kensington Rd. Kensington, CT 06037				
Report Prepared By Apple Health Care, Inc.	Phone Number (860) 678-9755		Date	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-828-0583	9/30/2016	2	37

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

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

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.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
David Desell	1861

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

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
Ledgecrest Health Care Center	154 Kensington Rd. Kensington, CT 06037	Connecticut

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

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General Information and Questionnaire
Individual Proprietorship

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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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	%**				
Brian J. Foley	21 Waterville Road Avon, CT	○	⊙		Real Estate Rental	Pg. 22 Line 9	348,000	348,000
Apple Health Care	21 Waterville Road Avon, CT	○	⊙		Management & Accounting Services	Pg. 16 Line m12	305,984	305,984
Healthport Services	21 Waterville Road Avon, CT	○	⊙		Employee Staffing	Pg. 10/13 Schedule	12,503	12,503
Allstar Therapy	21 Waterville Road Avon. CT	⊙	○	15%	Therapy Services	Pg. 13 B5/B9/B10	669,743	614,154
Corporate Employees	21 Waterville Road Avon, CT	○	⊙		Employee Staffing	Pg. 10 Schedule	8,408	8,408
Employees @ various Apple Facilities		○	⊙		Employee Staffing	Pg. 10 Schedule	14,215	14,215
Apple Health Care	21 Waterville Road Avon. CT	○	⊙		Pension Plan (401K)	Pg. 15 1a7	11,186	11,186
Aetna	PO Box 88860 Chicago, IL	⊙	○		Group Medical	Pg. 15 1a5	269,848	
Delta Dental	PO Box 23700 Newwark, NJ	⊙	○		Group Dental	Pg. 15 1a5	18,758	

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046-C	9/30/2016	4	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes x 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? x 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	%**				
Aetna Ancillary	PO Box 88860 Chicago, IL	X			Group Life & Disability	Pg. 15 1a6	21,757	
Marsh	PO Box 19636 Newark, NJ	X			Property, Liability, & Umbrella Insura	Pg. 27 14a	62,707	
AIG	PO Box 10472 Newark, NJ	X			Worker's Compensation	Pg. 15 1a1	46,112	
Swallowing Diagnostics	21 Waterville Rd. Avon, CT	X		83%	Diagnostic Services	Pg. 20 5f	3,600	3,395
Brendan Foley	21 Waterville Rd. Avon, CT		X			##		
Ryan Vess	21 Waterville Rd. Avon, CT		X			##		

* Use additional sheets if necessary.

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

Related expense has been disallowed on Pg. 28 Line 23

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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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.

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

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

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

N/A

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General Information and Questionnaire
Leases (Excluding Real Property)

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

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

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

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

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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 & Co. PC	29 South Main St. West Hartford, CT 06127
2 Brazee & Huban	35 Wendell Avenue Pittsfield, MA 10202
3	
4	

Services Provided by This Firm (*describe fully*)

1	Preparation of audited financials (dissallow Pg. 28)	$ 3,366
2	Preparation of tax returns	$ 2,068
3		$
4		$
		Charge for Services Provided $ 5,434

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

⊙ Yes ○ No | Pg. 15 1d

Legal Services Information

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

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	Collection Fees	$ 195
2		$
3		$
4		$
5		$
		Charge for Services Provided $ 195

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

⊙ Yes ○ No Pg. 15 1e

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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	60	60			60	60			60	60		
B. On last day of THIS report period	60	60			60	60			60	60		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	52	52			52	52			52	52		
B. As of midnight of THIS report period	53	53			53	53			53	53		
3. Total Number of Days Care Provided During Period												
A. Medicare	907	907			656	656			251	251		
B. Medicaid (Conn.)	16,223	16,223			12,359	12,359			3,864	3,864		
C. Medicaid (other states)												
D. Private Pay	2,420	2,420			1,701	1,701			719	719		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	19,550	19,550			14,716	14,716			4,834	4,834		
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)**	19,550	19,550			14,716	14,716			4,834	4,834		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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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	(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		3	40	10				
Per Diem Rate								
a. One bed rm.				407.00				
b. Two bed rms.	RUGS III	205.59		345.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	2,505	2,505		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	2,814	2,814		
D. ***Total Physical Therapy Treatments***	5,319	5,319		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	400	400		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	259	259		
D. ***Total Speech Therapy Treatments***	659	659		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,905	1,905		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	2,710	2,710		
D. ***Total Occupational Therapy Treatments***	4,615	4,615		

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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	(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)	78,803	2,120				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	11,580	835				
5. Dietary Service						
a. Head Dietitian	8,552	280				
b. Food Service Supervisor	48,286	2,177				
c. Dietary Workers	190,199	13,468				
6. Housekeeping Service						
a. Head Housekeeper	38,964	1,391				
b. Other Housekeeping Workers	70,585	4,894				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	75,039	4,092				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	26,017	1,151				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants	92,206	4,342				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	159,499	4,192				
b. RN						
1. Direct Care	404,483	10,756				
2. Administrative**	75,337	2,446				
c. LPN						
1. Direct Care	179,491	7,438				
2. Administrative**						
d. Aides and Attendants	709,383	45,431				
e. Physical Therapists	25,642	677				
f. Speech Therapists	113	4				
g. Occupational Therapists	71	2				
h. Recreation Workers	49,066	3,099				
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	40,471	2,069				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	2,283,787	110,864				

* 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**
Pointright	$ 3,300	33				
Total	$ 3,300	33	$ -	-	$ -	-

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

Name of Facility	License No.	Report for Year Ended	Page	of
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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
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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 III - Administrators* **										
David DeSell	78,803			Administrator 10/1/2015-9/30/2016		2,120	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
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	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	6,051	55				
3. Pharmacist	4,931	26				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	94,674	1,330				
b. Other						
6. Social Worker	500	3				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	19,200	60				
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)						
Other Physician Fees						
9. Speech Therapist						
a. Resident Care	31,918	165				
b. Other						
10. Occupational Therapist						
a. Resident Care	81,656	1,154				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	3,300	33				
B-13 Total Fees Paid in Lieu of Salaries	242,229	2,826				

* 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
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Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Allstar Therapy 21 Waterville Rd. Avon, CT	Therapy Services	⊙	○	See Disclosure Pg. 4
Healthport Services 21 Waterville Rd. Avon, CT	Employee Staffing	⊙	○	See Disclosure Pg. 4
Grove Hill Medical Center 300 Kensington Ave. New Britian, CT 06051	Medical Director	○	⊙	
Health Drive Dental 888 Worcester St. Wellesley, MA 02482	Dental	○	⊙	
Rosemary Spinelli-Reyes 55 Jodi Drive Wallingford, CT	Social Worker	○	⊙	
Pointright 150 Cambridge park Dr. Cambridge, MA	Data Integrity Auditor	○	⊙	
		○	⊙	
		○	⊙	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046-C	9/30/2016	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	46,112	46,112		
2. Disability Insurance	$				
3. Unemployment Insurance	$	37,327	37,327		
4. Social Security (F.I.C.A.)	$	157,401	157,401		
5. Health Insurance	$	208,627	208,627		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	21,757	21,757		
7. Pensions (Non-Discriminatory)	$	11,186	11,186		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	73,956	73,956		
d. Accounting and Auditing	$	5,434	5,434		
e. Legal (*Services should be fully described on Page 7)*	$	195	195		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	13,013	13,013		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	29,632	29,632		
2. Cellular Phones	$				
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$	250	250		
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	376,299	376,299		
Subtotal	$	981,191	981,191		

* 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)
Total	$ -	$ -	$ -

Schedule of Other Taxes

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

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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
Ledgecrest Health Care Center	2046-C	9/30/2016	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		981,191	981,191		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	616	616		
2. Holiday Parties for Staff	$	4,130	4,130		
3. Gifts to Staff and Residents	$	4,945	4,945		
4. Employee Travel	$	2,448	2,448		
5. Education Expenses Related to Seminars and Conventions	$	990	990		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	40	40		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	6,181	6,181		
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	$	854	854		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	4,139	4,139		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	986	986		
10. Contributions***	$	35	35		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$	305,984	305,984		
13. Other (*Specify*)	$	54,530	54,530		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	1,367,069	1,367,069		

* 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)
Advertising - Public Relations	$ 6,181		
Total Other Advertising	$ 6,181	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 4,139		
Total Dues	$ 4,139	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Detail or delete	$ 35		
Total Contributions	$ 35	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Corporate Fees - Non Reimbursable	$ 27,110		
Licenses & Fees	$ 4,322		
Pre Employment Screening	$ 8,756		
Point Click Care Fees	$ 8,095		
Bank Charges	$ 4,355		
Healthport Indirect	$ 2,691		
Prior Period Adj/Account W/O	$ (3,030)		
Account Write-Offs	$ 1,602		
User Fee Audit	$ 629		
Total Other Administrative and General	$ 54,530	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Ledgecrest Health Care Center	2046-C	9/30/2016	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 #
Apple Health Care, Inc.	305,984	Accounting & Managerial Services	Pg. 16 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
Ledgecrest Health Care Center	2046-C	9/30/2016	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	147,059	147,059		
2. Non-Food Supplies	$	36,865	36,865		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	2,844	2,844		
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	186,768	186,768		

2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals:	Total no. of meals served per day:*	161	161		

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
Ledgecrest Health Care Center	2046-C	9/30/2016	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $	3,843	3,843		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	54,740	54,740		
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	58,582	58,582		

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
Ledgecrest Health Care Center	2046-C	9/30/2016	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.	$	24,462	24,462		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	24,462	24,462		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from West River Pharmacy		$	17,668	17,668		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	103,976	103,976		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$				
f. X-rays and Related Radiological Procedures***		$	5,231	5,231		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	2,822	2,822		
i. Recreation		$	24,434	24,434		
j. Other (Specify)**** See Attached Schedule		$	11,571	11,571		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	165,702	165,702		

* 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)
Nursing Station Supplies	$ 4,836		
Rehab Service Supplies	$ 4,822		
IV Therapy Supplies	$ 1,914		
Social Service Supplies	$ -		
Total Other Resident Care	$ 11,571	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046-C	9/30/2016	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
Matthew Gilbert	838 Beckley Road Berlin, CT 06037	○	⊙		Lawn Care	12,684			22	6a
CWPM	415 Plainville, CT 06062	○	⊙		Refuse Removal	15,756			22	6f
Unitex	Pkwy. Mt. Vernon, NY 06114	○	⊙		Laundry	53,488			19	3b
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Ledgecrest Health Care Center	2046-C	9/30/2016	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	138,466	138,466		
b. Heat	$	27,089	27,089		
c. Light & Power	$	41,536	41,536		
d. Water	$	9,490	9,490		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	15,756	15,756		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	232,337	232,337		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	1,431	1,431		
d. Movable Equipment	$	3,165	3,165		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	4,595	4,595		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	7,280	7,280		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	7,280	7,280		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	348,000	348,000		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	37,127	37,127		
c. Personal property taxes	$	2,595	2,595		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	399,597	399,597		

* 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)
Refuse Removal	$ 15,756		
Total Other Repairs and Maintenance	$ 15,756	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046-C	9/30/2016	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								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	39,287		39,287	33,165	SL	Various	1,431	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								1,431

	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					125,946		125,946	116,926	SL	Various	3,165	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)												
D-3. Subtotal												3,165
E. ***Total Depreciation***												4,595

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Schedule of Land Improvements Acquired during this report period

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

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

Schedule of Building Improvements Acquired during this report period

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

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

Schedule of Non-Movable Equipment Acquired during this report period

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Movable Equipment		$ -		$ -	*
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
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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				490,041	447,729	A		7,280	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									7,280
D. ***Total Amortization***									7,280

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
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11. Property Questionnaire

Part A

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

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

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

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

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)	See Attached			
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

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.

	Original Mortgage	6 Month extension
A. Type of Financing (e.g. fixed, variable)	Fixed	
B. Date of Mortgage Obtained	4/11/2008	extension to 10/13/15
C. Interest Rate For the Cost Year	6.44%	2.08%
D. Term of Mortgage (number of years)	7 Yrs.	6 month
E. Amount of Principal Borrowed	119,500,000	
F. Principal Balance Outstanding as of 9/30/	100,562,320	12 month extension
		extention to 10/13/16
Note: The following facilities are collateralized by this mortgage.		2.75%
		12 months

Connecticut Facilities

Brightview Nursing & Retirement Center, Ltd.
Rose Haven, Ltd.
Mary Elizabeth Nursing Center, Inc.
Fowler Nursing Center, Inc.
Waterbury Extended Care Facility, Inc.
Harbor View Nursing Center, Inc.
Liberty Hall Nursing Center
Orchard Grove Specialty Care
Wolcott Hall Nursing Center, Inc.
Hewitt Health and Rehabilitation Center, Inc.
Watrous Nursing Center
Elm Hill Nursing Center, Inc.
Gardner Heights Health Care Center, Inc.
Shelton lakes Health Care Center, Inc.
Highview Health Care Center, Inc.
Westfield Manor Health Care Center, Inc.
TA Coccomo Memorial
Plainville Health Care Center, Inc.
Ledgecrest Health Care Center, Inc.
Ridgeview Health Care Center, Inc.
The Kent, Ltd.
Chesterfields, Ltd.

Out of State Facilities

Watch Hill Manor, Ltd.
The Clipper Home, Inc.

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

Name of Facility	License No.	Report for Year Ended	Page of
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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
Ledgecrest Health Care Center	2046-C	9/30/2016	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*) $	159	159		
Value Settlement				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	159	159		
14. Insurance				
a. Insurance on Property (buildings only) $	62,707	62,707		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $				
2. Fire and Extended Coverage $				
3. Other (*Specify*) $				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	62,707	62,707		
15. ***Total All Expenditures (A-13 thru C-14)*** $	5,023,400	5,023,400		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Ledgecrest Health Care Center	2046-C	9/30/2016	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.	10	A12g	Occupational Therapy $	71	71		
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	B10a	Occupational Therapy $	81,656	81,656		
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	73,956	73,956		
10.	15	1d/e	Accounting & Legal $	3,561	3,561		
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.	16	m2/3	Unallowable Advertising * $	6,181	6,181		
19.			Income Tax / Corporate Business Tax $				
20.	16	m10	Fund Raising / Contributions $	35	35		
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	57,570	57,570		
Page 18 - Dietary Expenditures							
24.	30	IV1	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) $	223,029	223,029		

* 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)
Total Other Fees Adjustments			$ -	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Corporate Fee - Non Reimbursable	$ 27,110		
16	1.3	Employee Recognition/Gift/Parties	$ 4,945		
16	8a	Chamber of Commerce	$ -		
16	m13	Bank Charges	$ 4,355		
30	IV8	Dividends/ Rebates	$ 24,189		
16	m13	Prior Period Adj/Account W/O	$ (3,030)		
Total Other A&G Adjustments			$ 57,570	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
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Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	223,029	223,029		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs $	17,668	17,668		
28.	16	L1	Ambulance/Limousine $	616	616		
29.	20	h	X-rays, etc $	5,231	5,231		
30.	20	f	Laboratory $	2,822	2,822		
31.			Medical Supplies $				
32.	20	5e2	Oxygen (non emergency) $				
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	6,735	6,735		
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 $	0			
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)*** $			256,100	256,100		

*** 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

Ledgecrest Health Care Center
9/30/2016

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	IV Therapy Supples	$ 1,914		
20	5j	Rehab Service Supplies	$ 4,822		
Total Other Ancillary Costs			$ 6,735	$ -	$ -

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)
Total Other Property Adjustments			$ -	$ -	$ -

Schedule of Other Adjustments

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

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
Ledgecrest Health Care Center	2046-C	9/30/2016	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	3,340,465	3,340,465		
b. Medicaid Room and Board Contractual Allowance **	$				
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	340,914	340,914		
b. Medicare Room and Board Contractual Allowance **	$	140,366	140,366		
4. a. Private-Pay Residents and Other	$	906,243	906,243		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	28,812	28,812		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(28,812)	(28,812)		
c. Prescription Drugs - Non-Medicare	$	11,859	11,859		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(11,859)	(11,859)		
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	$	166,741	166,741		
b. Physical Therapy - Medicare Contractual Allowance **	$	(93,182)	(93,182)		
c. Physical Therapy - Non-Medicare	$	19,425	19,425		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(19,425)	(19,425)		
4. a. Speech Therapy - Medicare	$	27,496	27,496		
b. Speech Therapy - Medicare Contractual Allowance **	$	(12,394)	(12,394)		
c. Speech Therapy - Non-Medicare	$	2,160	2,160		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(2,160)	(2,160)		
5. a. Occupational Therapy - Medicare	$	184,681	184,681		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(112,758)	(112,758)		
c. Occupational Therapy - Non-Medicare	$	22,995	22,995		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(22,995)	(22,995)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	4,888,572	4,888,572		
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)*	$	0	0		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	24,222	24,222		
V. Total Other Revenue (1 thru 8)	$	24,222	24,222		
VI. Total All Revenue (III +V)	$	4,912,794	4,912,794		

* *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)
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30 IV5	Interest Income	707,624	$ 0		
Total Interest Income			$ 0	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV 8	Prior Period Corrections	$ 3		
30 IV 8	Insurance Gain	$ 11,994		
30 IV 8	UHC/Optum Dividends	$ 12,195		
30 IV 8	Medical Records	$ 30		
Total Other Revenue		$ 24,222	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046-C	9/30/2016	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 2,404
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 707,624
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 14,135
5. Prepaid Expenses				$ 13,772
a. Prepaid Insurance				
b. Prepaid Property Tax		11,972		
c. Other Prepaid Expenses		1,800		
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 5,601
Due Affiliate (Debit Balance)				
A/P Patient Exchange		3,124		
HCRA /DCRA		2,175		
Payroll Deduction life insurance		301		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 743,537
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	490,041		$ 35,032
	Accum. Depreciation	455,009	Net	
5. Non-Movable Equipment	*Historical Cost	39,287		$ 4,691
	Accum. Depreciation	34,596	Net	
6. Movable Equipment	*Historical Cost	125,946		$ 5,856
	Accum. Depreciation	120,091	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
Fixed Asset Clearning Account				
Construction in Progress				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 45,579

* 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
Ledgecrest Health Care Center	2046-C	9/30/2016	32	37

Account				Amount
			Total Brought Forward:	$ 789,116
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*)				$
Loans Rec. - Officers/Owner				
Capitalized Refinance Expense				
Leasehold Deposits				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 789,116

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046-C	9/30/2016	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 132,445
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*)	$ 71,147
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$ 5,875
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*)	$ 644,444

Accrued PTO	93,766	Accrued Professional Fee	5,089
Accrued Pension	2,388	Payroll W/H	2,448
Accrued Worker's Comp	68,356	Due Affiliate (Credit Bal	349,767
Accrued Expense Other	119,813	Exchange- Donations	2,817

A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 853,912

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046-C	9/30/2016	34	37

Account				Amount
			Total Brought Forward:	853,912
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*)				$ 606,269
Name and Address of Lender	Amount	Loan Date		
Brian J. Foley	606,269	Demand		
4. Other Long-Term Liabilities (*itemize*)				$
Security Deposits				
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ 606,269
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 1,460,182

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

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046-C	9/30/2016	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	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$ 4,028,186
	2. Capital Stock	$ 1,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (4,589,646)
	6. Gain or Loss for Period 10/1/2015 thru 9/30/2016	$ (110,607)
	7. Total Net Worth	$ (671,066)
C.	***Total Reserves and Net Worth***	$ (671,066)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 789,116

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046-C	9/30/2016	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2015			$ (907,192)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 4,912,794
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 5,023,400
D.	Net Income or Deficit			$ (110,607)
E.	Balance			$ (1,017,799)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Brian Foley	350,000		
	2. Other (*itemize*)			
F-3.	Total Additions			$ 350,000
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$ 3,268
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	Brian Foley	President	3,268	
	2. Other Withdrawings *(Specify)*			$
	Purpose	Amount		
	3. Total Deductions			$ 3,268
H.	***Balance at End of Period***	09/30/16		$ (671,067)