State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2018

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 10/1/2017	Report for Year Ending 9/30/2018	

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046-C	9/30/2018	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, 2017 and ending September 30, 2018, 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) Dave 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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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 10/1/2017	To 9/30/2018
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
860-678-9755	9/30/2018	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

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	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	001861

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
Ledgecrest Health Care Center	2046-C	9/30/2018	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
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
Ledgecrest Health Care Center	2046-C	9/30/2018	4	37

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 06001	○	⊙		Real Estate Rental	Pg. 22 Line 9	264,000	264,000
Apple Health Care	21 Waterville Road Avon, CT 06001	○	⊙		Management & Accounting Services	Pg. 16 Line m12	151,734	151,734
Corporate Employees	21 Waterville Road Avon, CT 06001	○	⊙		Employee Staffing	Pg. 10 Schedule	98,407	98,407
Employees @ Various Apple Facilities		○	⊙		Employee Staffing	Pg. 10 Schedule	145,139	145,139
Apple Health Care	21 Waterville Road Avon, CT 06001	○	⊙		Pension Plan (401K)	Pg. 15 Line 1a7	15,548	15,548
Aetna	PO Box 88860 Chicago, IL 60695	⊙	○		Group Medical	Pg. 15 Line 1a5	131,503	
Delta Dental	PO Box 222 Parsippany, NJ 07054	⊙	○		Group Dental	Pg. 15 Line 1a5	16,167	
Aetna Ancillary	PO Box 88860 Chicago, IL 60695	⊙	○		Group Life & Disability	Pg. 15 Line 1a6	14,960	
Marsh	PO Box 846015 Dallas, TX 75284	⊙	○		Property, Liability, & Umbrella Insurance	Pg. 27 Line 14a	59,217	

* 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	9/30/2018	4	37

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	%**				
AIG	PO Box 10472 Newark, NJ	✠			Worker's Compensation	Pg. 15 1a1	57,396	
Swallowing Diagnotics	21 Waterville Road Avon, CT	✠		83%	Diagnostic Services	Pg 20 5f	2,520	2,376
Ryan Vess	21 Waterville Road Avon, CT		✠			##		

* 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
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
						Total ***	

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

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

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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 Ave. Pittsfield, MA 10202
3	
4	

Services Provided by This Firm (*describe fully*)	
1 Preparation of audited financials (disallow Pg.28)	$ 6,442
2 Preparation of tax returns	$ 2,206
3	$
4	$
	Charge for Services Provided $ 8,648

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	
2	
3	
4	
5	

Address (*No. & Street, City, State, Zip Code*)
1
2
3
4
5

Services Provided by This Firm (*describe fully*)	
1	$
2	$
3	$
4	$
5	$
	Charge for Services Provided $

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

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (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	45	45			45	45			51	51		
B. As of midnight of THIS report period	51	51			51	51			51	51		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,492	1,492			1,313	1,313			179	179		
B. Medicaid (Conn.)	14,780	14,780			10,751	10,751			4,029	4,029		
C. Medicaid (other states)												
D. Private Pay	2,109	2,109			1,592	1,592			517	517		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	18,381	18,381			13,656	13,656			4,725	4,725		
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)**	18,381	18,381			13,656	13,656			4,725	4,725		

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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	2	43		6				
Per Diem Rate								
a. One bed rm.				295.00				
b. Two bed rms.	RUGS III	204.16		250.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	8,184	8,184		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	3,748	3,748		
D. ***Total Physical Therapy Treatments***	11,932	11,932		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	433	433		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	474	474		
D. ***Total Speech Therapy Treatments***	907	907		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	7,592	7,592		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	3,793	3,793		
D. ***Total Occupational Therapy Treatments***	11,385	11,385		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046-C	9/30/2018	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)	94,855	2,126				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	31,986	2,169				
5. Dietary Service						
a. Head Dietitian	560	16				
b. Food Service Supervisor	42,921	2,048				
c. Dietary Workers	187,156	12,254				
6. Housekeeping Service						
a. Head Housekeeper	53,009	2,066				
b. Other Housekeeping Workers	66,466	4,593				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	62,534	3,150				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	14,355	655				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants	46,553	2,023				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	76,228	1,720				
b. RN						
1. Direct Care	419,125	10,847				
2. Administrative**	64,195	1,658				
c. LPN						
1. Direct Care	190,474	7,345				
2. Administrative**						
d. Aides and Attendants	632,309	37,118				
e. Physical Therapists	214,595	5,268				
f. Speech Therapists	26,252	675				
g. Occupational Therapists	162,918	4,282				
h. Recreation Workers	40,173	2,248				
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	36,361	1,841				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	2,463,024	104,100				

* 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**
Connecticut Purchasig Consultants	$ 4,762	49				
Patientping Inc	$ 2,341	23				
Pointright Inc	$ 3,300	33				
Total	$ 10,404	105	$ -	-	$ -	-

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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* **										
Kerri Kuhn	24,930				Administrator 10/1/17 - 12/16/17	480	A2	Apple Rehab - Watrous	1,646	79,290
David Desell	69,926				Administrator 12/17/17 - 9/30/18	1,646	A2	Apple Rehab - Coccomo	480	20,105
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
Ledgecrest Health Care Center	2046-C	9/30/2018	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	6,942	64				
3. Pharmacist	3,184	17				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	15,300					
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						
b. Other						
10. Occupational Therapist						
a. Resident Care						
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	10,404	105				
B-13 Total Fees Paid in Lieu of Salaries	35,830	185				

* 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	
Starling Physicians 1260 Silas Deane Hwy, Wethersfield, CT 06109	Medical Director	○	⊙	
Pointright Inc 150 Cambridge Park Dr, Cambridge, MA 02140	Data Integity Audit	○	⊙	
Connecticut Purchasing Consultants Stratford, CT	Purchasing Consultant	○	⊙	
Patient Ping Boston, MA	A&D Fees	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

* 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	9/30/2018	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	57,396	57,396		
2. Disability Insurance	$				
3. Unemployment Insurance	$	35,076	35,076		
4. Social Security (F.I.C.A.)	$	161,967	161,967		
5. Health Insurance	$	68,065	68,065		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	14,960	14,960		
7. Pensions (Non-Discriminatory)	$	15,548	15,548		
(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*	$	315,606	315,606		
d. Accounting and Auditing	$	8,648	8,648		
e. Legal (*Services should be fully described on Page 7)*	$				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	8,845	8,845		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	33,184	33,184		
2. Cellular Phones	$				
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	354,355	354,355		
Subtotal	$	1,073,649	1,073,649		

* 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	9/30/2018	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,073,649	1,073,649		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	2,758	2,758		
3. Gifts to Staff and Residents	$	7,062	7,062		
4. Employee Travel	$	3,561	3,561		
5. Education Expenses Related to Seminars and Conventions	$	457	457		
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*)	$				
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	13,144	13,144		
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	$	549	549		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	5,539	5,539		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	1,637	1,637		
10. Contributions*** 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**	$	151,734	151,734		
13. Other (*Specify*) See Attached Schedule	$	65,960	65,960		
C-14 Total Administrative & General Expenditures	$	1,326,052	1,326,052		

* 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	$ 13,144		
Total Other Advertising	$ 13,144	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 5,494		
Sam's Club Yearly Membership	$ 45		
Total Dues	$ 5,539	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Corporate Fees Non Reimbursable	$ 31,507		
Licenses & Fees	$ 6,759		
Pre Employment Screenings	$ 3,633		
Point Click Care Fees	$ 8,995		
Bank Charges, Penalties, Fees	$ 13,575		
Legal Fees - Collections, Probate, Conservator	$ 605		
Resident Expenses	$ -		
Account W/O	$ 886		
Total Other Administrative and General	$ 65,960	$ -	$ -

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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	9/30/2018	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.	151,734	Accounting & Management 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 of
Ledgecrest Health Care Center	2046-C	9/30/2018	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	119,645	119,645		
2. Non-Food Supplies	$	13,394	13,394		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	1,566	1,566		
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	134,605	134,605		

2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals:	Total no. of meals served per day:*	151	151		

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.

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

Name of Facility	License No.	Report for Year Ended	Page of
Ledgecrest Health Care Center	2046-C	9/30/2018	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. $	1,576	1,576		
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. $	1,635	1,635		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	43,620	43,620		
c. Other (*Specify*)	$				
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	46,831	46,831		

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.

*** 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	9/30/2018	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.	$	8,498	8,498		
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	8,498	8,498		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from West River/Neighborcare		$	72,310	72,310		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	77,528	77,528		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	7,551	7,551		
f. X-rays and Related Radiological Procedures***		$	7,708	7,708		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	5,734	5,734		
i. Recreation		$	20,964	20,964		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	10,988	10,988		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	202,783	202,783		

* 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	$ 328		
Rehab Service Supplies	$ 2,903		
IV Therapy	$ 7,757		
Total Other Resident Care	$ 10,988	$ -	$ -

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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	9/30/2018	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
CWPM	25 Norton Pl. Plainville, CT 06062	○	⊙		Refuse Removal	17,236			22	6f
Marc's Landscaping	PO BOX 7011 Berlin, CT	○	⊙		Snow Removal & Landscaping	11,077			22	6A
Unitex Textile Rental	Pkwy Mt Vernon, NY 10550	○	⊙		Textile Rental	47,956			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	9/30/2018	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	111,689	111,689		
b. Heat	$	27,711	27,711		
c. Light & Power	$	39,698	39,698		
d. Water	$	16,711	16,711		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	16,462	16,462		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	212,271	212,271		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	1,415	1,415		
d. Movable Equipment	$	5,464	5,464		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	6,879	6,879		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	6,922	6,922		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	6,922	6,922		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	264,000	264,000		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	35,108	35,108		
c. Personal property taxes	$	2,543	2,543		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	315,451	315,451		

* 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	$ 16,462		
Total Other Repairs and Maintenance	$ 16,462	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046-C	9/30/2018	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	36,027	SL	VAR	1,415	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								1,415

	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					142,266		142,266	126,717	SL	VAR	5,363	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					1,487		1,487		SL	VAR	101	
D-3. Subtotal												5,464
E. ***Total Depreciation***												6,879

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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 Improvement		$ -		$ -	*
Deletions:					
Total deletions for Land Improvement		$ -		$ -	**

***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 Improvement		$ -		$ -	*
Deletions:					
Total deletions for Building Improvement		$ -		$ -	**

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

Schedule of Non-Movable Equipment Acquired during this report peri

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

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

Schedule of Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
3/22/2018	CAP #2142 Badge Maker	$ 1,487	ME-5	$ 101	
Total additions for Movable Equipmen		$ 1,487		$ 101	*
Deletions:					
Total deletions for Movable Equipmen		$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report peri

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

***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				493,747	462,104	A		6,922	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									6,922
D. ***Total Amortization***									6,922

* 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
Ledgecrest Health Care Center	2046-C	9/30/2018	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	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)	Variable			
b. Date Mortgage Obtained	12/07/16			
c. Interest Rate for the Cost Year	4.48%			
d. Term of Mortgage (number of years)	5 Years			
e. Amount of Principal Borrowed	1,993,545			
f. Principal balance outstanding as of _____	1,903,836			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
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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	9/30/2018	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*) $				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $				
14. Insurance				
a. Insurance on Property (buildings only) $	59,217	59,217		
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)*** $	59,217	59,217		
15. ***Total All Expenditures (A-13 thru C-14)*** $	4,804,562	4,804,562		

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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	9/30/2018	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 $	162,918	162,918		
4.			Other - See attached Schedule $	4,172	4,172		
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	B10a	Occupational Therapy $				
7.			Other - See attached Schedule $	15,300	15,300		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	315,606	315,606		
10.	15/16	1d/m	Accounting $	7,047	7,047		
10a.			Legal $				
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 * $	13,144	13,144		
19.			Income Tax / Corporate Business Tax $				
20.	16	m10	Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	53,630	53,630		
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) $	571,816	571,816		

* 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)
VAR	VAR	Social Services - Marketing	$ 4,172		
Total Other Salaries Adjustment			$ 4,172	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B8A	Medical Director	$ 15,300		
Total Other Fees Adjustments			$ 15,300	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Corp Fee- Non-reimbursable	$ 31,507		
16	1.3	Employee Recognition/Gifts/Parties	$ 7,062		
16	8a	Chamber of Commerce	$ -		
16	m13	Bank Charges, penalties, fines	$ 13,575		
16	m13	Resident Expenses	$ -		
16	m13	Account W/O	$ 886		
30	IV8	Settlement	$ 600		
Total Other A&G Adjustments			$ 53,630	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Ledgecrest Health Care Center	2046-C	9/30/2018	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	571,816	571,816		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs $	72,180	72,180		
28.	16	L1	Ambulance/Limousine $				
29.	20	h	X-rays, etc $	7,708	7,708		
30.	20	f	Laboratory $	5,734	5,734		
31.			Medical Supplies $				
32.	20	5e2	Oxygen (non emergency) $	6,073	6,073		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	10,659	10,659		
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.			Other - Indirect $				
43.	30	IV5	Interest Income on Account Rec. $	37	37		
44.			Other - Miscellaneous Administrative $				
45.			Management Fees Direct $				
46.			Management Fees Indirect $				
47.			Other - Direct $				
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
49. ***Total Amount of Decrease (Items 1 - 48)***			$	674,208	674,208		

*** 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
9/30/2018

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	IV Therapy Supplies	$ 7,757		
20	5j	Rehab Service Supplies	$ 2,903		
Total Other Ancillary Costs			$ 10,659	$ -	$ -

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)
27	12D	Interest	$ -		
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	9/30/2018	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	2,949,249	2,949,249		
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)*	$	571,307	571,307		
b. Medicare Room and Board Contractual Allowance **	$	202,904	202,904		
4. a. Private-Pay Residents and Other	$	928,616	928,616		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	24,993	24,993		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(25,210)	(25,210)		
c. Prescription Drugs - Non-Medicare	$	19,472	19,472		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(23,162)	(23,162)		
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	$	372,053	372,053		
b. Physical Therapy - Medicare Contractual Allowance **	$	(146,374)	(146,374)		
c. Physical Therapy - Non-Medicare	$	45,559	45,559		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(47,215)	(47,215)		
4. a. Speech Therapy - Medicare	$	30,511	30,511		
b. Speech Therapy - Medicare Contractual Allowance **	$	(15,159)	(15,159)		
c. Speech Therapy - Non-Medicare	$	10,305	10,305		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(10,305)	(10,305)		
5. a. Occupational Therapy - Medicare	$	450,677	450,677		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(181,508)	(181,508)		
c. Occupational Therapy - Non-Medicare	$	61,650	61,650		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(61,650)	(61,650)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	8	8		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	5,156,722	5,156,722		
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)*	$	37	37		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	13,200	13,200		
V. Total Other Revenue (1 thru 8)	$	13,237	13,237		
VI. Total All Revenue (III +V)	$	5,169,960	5,169,960		

* *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)
	Private Oxygen	$ 8		
Total Other Resident Revenue		$ 8	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30	Interest on Accounts Receivable	984,628	$ 37		
Total Interest Income			$ 37	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV8	Settlement	$ 600		
30 IV8	OPTUM /UHC Dividend	$ 12,600		
Total Other Revenue		$ 13,200	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046-C	9/30/2018	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 984,628
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 9,642
5. Prepaid Expenses				$ 21,194
a.				
b.				
c.				
d. See Schedule		21,194		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 2,175
See Schedule		2,175		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,017,639
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	493,747		$ 24,722
	Accum. Depreciation	469,026	Net	
5. Non-Movable Equipment	*Historical Cost	39,287		$ 1,845
	Accum. Depreciation	37,442	Net	
6. Movable Equipment	*Historical Cost	143,752		$ 11,571
	Accum. Depreciation	132,181	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 38,138

* 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	9/30/2018	32	37

Account				Amount
			Total Brought Forward:	$ 1,055,777
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*)				$
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 1,055,777

* 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	9/30/2018	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 239,412
2. Notes Payable (*itemize*)	$
See Schedule	
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*)	$ 49,406
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$ 6,711
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*)	$ 421,627
See Schedule 421,627	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 717,156

* 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	9/30/2018	34	37

Account	Amount
Total Brought Forward:	717,156
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*)	$	895,165
See Schedule 895,165		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$	895,165
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$	1,612,321

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	A5	Prepaid Insurance	$ 0
31	A5	Prepaid Property Tax	$ 19,394
31	A5	Prepaid Other	$ 1,800
Total Prepaid Expenses			$ 21,194

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

Page Ref	Line Ref	Description	
31	A8	Employee Withholding (HCRA/DCRA)	$ 2,175
Total Other Current Assets (Itemize)			$ 2,175

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

Page Ref	Line Ref	Description	
31	B9	Fixed Asset Clearing Account	$ -
31	B9	Construction in Progress	$ -
Total Other Other Fixed Assets (Itemize)			$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Loans Rec. - Officers/Owners	$ -
		Capitalized Refinance	$ -
		Leasehold Deposits	$ -
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

Page Ref	Line Ref	Description	
33	A12	Accrued PTO	$ 96,134
33	A12	Accrued Pension	$ 513
33	A12	Accrued Worker's Comp	$ 38,744
33	A12	Accrued Expense Other	196,965.86
33	A12	Accrued Professional Fees	7,137.48
33	A12	Payroll W/H	2,069.01
33	A12	Due Affiliate (Credit Balance)	73,671.64
33	A12	Gemino Revolving Loan	0.00
33	A12	Exchange	88.93
33	A12	A/P Patient Exchange	6,302.04
Total Other Current Liabilities (Itemize)			$ 421,627

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

Page Ref	Line Ref	Description	
34	B4	A/P Other	$ 895,165
Total Other Current Liabilities (Itemize)			$ 895,165

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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	9/30/2018	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	$ (4,951,128)
	6. Gain or Loss for Period 10/1/2017 thru 9/30/2018	$ 365,398
	7. Total Net Worth	$ (556,544)
C.	***Total Reserves and Net Worth***	$ (556,544)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 1,055,777

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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	9/30/2018	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2017			$ (919,107)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 5,169,960
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 4,804,562
D.	Net Income or Deficit			$ 365,398
E.	Balance			$ (553,709)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$ 2,835
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	Brian Foley	President	2,835	
	2. Other Withdrawings *(Specify)*			$
	Purpose	Amount		
	3. Total Deductions			$ 2,835
H.	***Balance at End of Period*** 09/30/18			$ (556,544)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Ledgecrest Health Care Center	2046-C	9/30/2018	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
Robert Gwizdak

Addres Address	Phone Number
21 Waterville Road Avon, CT 06001	(860) 678-9755

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