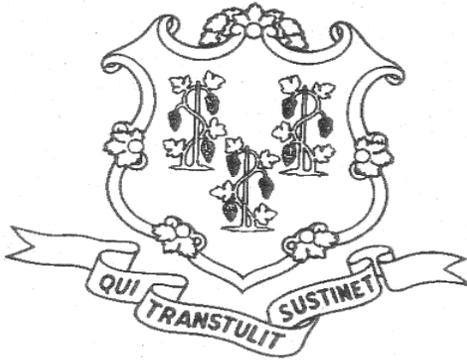


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2022

Name of Facility (as licensed) Leeway, Inc	
Address (No. & Street, City, State, Zip Code) 40 Albert St., New Haven, CT	
Type of Facility Chronic and Convalescent                      Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only <input type="checkbox"/> Supervision only <input checked="" type="checkbox"/> Residential Care Home (CCNH)                      (RHNS)	
Report for Year Beginning 10/1/2021	Report for Year Ending 9/30/2022

License Numbers:	CCNH 2167-C	RHNS	Residential Care Home 1891-RCH	Medicare Provider 07-5408
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Medicaid Provider Numbers:	CCNH 42169	RHNS	ICF-IID
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**For Department Use Only**

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

### General Information

Name of Facility (as licensed) Leeway, Inc	License No. 2167-C	Report for Year Ended 9/30/2022	Page 1	of 37
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#### Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Leeway, Inc [facility name], for the cost report period beginning October 1, 2021 and ending September 30, 2022, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) Jay Katz			Printed Name (Owner) William Dyson, Chairman		
Subscribed and Sworn to before me:	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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Leeway, Inc		Period Covered:	From 10/1/2021	To 9/30/2022
Address of Facility 40 Albert St., New Haven, CT				
Report Prepared By Robert Morgan, CPA		Phone Number 941-303-3958	Date 2/15/2023	
Item	Total	CCNH	RHNS	Residential Care Home
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

**General Information and Questionnaire**  
**Type of Facility - Organization Structure**

Phone No. of Facility 203 865-0068		Report for Year Ended 9/30/2022		Page 2	of 37
Name of Facility (as shown on license) Leeway, Inc			Address (No. & Street, City, State, Zip) 40 Albert St., New Haven, CT		
License Numbers:	CCNH 2167-C	RHNS	Residential Care Home 1891-RCH	Medicare Provider No. 07-5408	
Type of Facility (Check appropriate box(es))					
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input checked="" type="checkbox"/> Residential Care Home	
Type of Ownership (Check appropriate box)					
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input checked="" type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust					
If this facility opened or closed during report year provide:			Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No   If "Yes," explain fully.					
<b>Administrator</b>					
Name of Administrator Jay Katz			Nursing Home Administrator's License No.:	002085	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		



**General Information and Questionnaire  
 Corporate Owners**

Name of Facility Leeway, Inc	License No. 2167-C	Report for Year Ended 9/30/2022	Page 3A	of 37
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If this facility is owned or operated as a corporation, provide the following information:

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

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
William Dyson		Chairman	
Patricia Comer, Vice Chairperson			
Russell Barbour, PhD			
Stuart Sidle, PhD			
Kathryn, Sylvester, Esq.			
Names of Stockholders Owning at Least 10% of Shares			
Frederick Streets, PhD			
Jeffrey Busk			
Elaine Anderson			
Robert Morgan, CPA			
Michael Dunn, Esq.			



**General Information and Questionnaire  
 Related Parties\***

Name of Facility Leeway, Inc	License No. 2167-C	Report for Year Ended 9/30/2022	Page 4	of 37
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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	%**				
Robert Morgan, CPA		<input type="radio"/>	<input checked="" type="radio"/>		Cost Reporting and other reimb. Services	10, A.4	15,558	15,558
Leeway Putnam Housing		<input type="radio"/>	<input checked="" type="radio"/>		Office Space Rental			
Leeway Welton Housing		<input type="radio"/>	<input checked="" type="radio"/>		Office Space Rental			
Leeway Scattered Site Housing		<input type="radio"/>	<input checked="" type="radio"/>		None			
Michael Dunn, Esq., Greentree Risk Management		<input checked="" type="radio"/>	<input type="radio"/>	98%	Labor Relations Risk Management	15, 1.e	3,000	3,000
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

\* Use additional sheets if necessary.  
 \*\* Provide the percentage amount of revenue received from non-related parties.

## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility Leeway, Inc	License No. 2167-C	Report for Year Ended 9/30/2022	Page 5	of 37
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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 ( <i>See listing page 13</i> )
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

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

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

2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.  
 Costs associated with management oversight of housing and grants has been eliminated from the cost report along with direct costs associated with each grant program. The details are included on the general ledger cross reference schedule included with the cost report submission.

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

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

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

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

Name of Facility			License No.	Report for Year Ended			Page	of
Leeway, Inc			2167-C	9/30/2022			6	37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
Pitney Bowes	<input type="radio"/>	<input checked="" type="radio"/>	Postage Meter		with auto renewal	785	785	
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
<b>Is a Mileage Log Book Maintained for All Leased Vehicles ?</b>							<input checked="" type="radio"/> Yes	<input type="radio"/> No
<b>Total ***</b>							785	

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

### General Information and Questionnaire Accounting Basis

Name of Facility Leeway, Inc	License No. 2167-C	Report for Year Ended 9/30/2022	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:  
 Accrual     Cash     Modified Cash

Is the accounting basis for this period the same as for the previous period?     Yes     No    If "No," explain.

**Independent Accounting Firm**

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

Services Provided by This Firm (*describe fully*)

1 Audited Financial Statements, Single Audit, and Form 990	\$	37,830
2 Note: Costs associated with Consolidation are paid proportionately by each entity.	\$	
3	\$	
4	\$	
	Charge for Services Provided	
	\$	37,830

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.  
 Yes     No    Page 15

**Legal Services Information**

Name of Legal Firm or Independent Attorney	Telephone Number
1 Greentree Labor Risk Management	
2 Wiggins & Dana	
3	
4	
5	

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

Services Provided by This Firm (*describe fully*)

1 Legal Labor Relations Risk Management	\$	3,000
2 DPH related Issues	\$	1,572
3 DPH related Issues	\$	436
4	\$	
5	\$	
	Charge for Services Provided	
	\$	5,008

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.  
 Yes     No    Page 15

**Schedule of Resident Statistics**

Name of Facility Leeway, Inc			License No. 2167-C		Report for Year Ended 9/30/2022				Page 8	of 37		
	Total All Levels	Total CCNH Level	Total RHNS Level	Total Residential Care Home	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Residential Care Home	Total	CCNH	RHNS	Residential Care Home
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	60	30		30	60	30		30				
B. On last day of THIS report period	60	30		30					60	30		30
2. Number of Residents												
A. As of midnight of PREVIOUS report period	58	29		29	58	29		29				
B. As of midnight of THIS report period	57	30		27					57	30		27
3. Total Number of Days Care Provided During Period												
A. Medicare	1,180	1,180			983	983			197	197		
B. Medicaid (Conn.)	9,275	9,275			6,735	6,735			2,540	2,540		
C. Medicaid (other states)												
D. Private Pay	456	61		395	364	61		303	92			92
E. State SSI for RCH	10,180			10,180	7,514			7,514	2,666			2,666
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	21,091	10,516		10,575	15,596	7,779		7,817	5,495	2,737		2,758
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. <b>Total Resident Days (3G + 4A + 4B)</b>	21,091	10,516		10,575	15,596	7,779		7,817	5,495	2,737		2,758

### Schedule of Resident Statistics (Cont'd)

Name of Facility Leeway, Inc			License No. 2167-C			Report for Year Ended 9/30/2022			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH (1)	RHNS (2)	Residential Care Home (3)	Lost			Gained			CCNH	RHNS	Residential Care Home	
				(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days									CCNH	RHNS	Residential Care Home		
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH		CCNH	RHNS	CCNH	RHNS	Residential Care Home	R.C.H.	ICF-MR				
No. of Residents	1		29				1	26					
Per Diem Rate													
a. One bed rm.	Various		473.55		500.00		170.00	166.55					
b. Two bed rms.													
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	Residential Care Home	
A. Medicare - Part B									365	365			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									469	469			
C. Other									886	886			
D. <b>Total Physical Therapy Treatments</b>									1,720	1,720			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									46	46			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									148	148			
C. Other									41	41			
D. <b>Total Speech Therapy Treatments</b>									235	235			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									216	216			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									375	375			
C. Other									672	672			
D. <b>Total Occupational Therapy Treatments</b>									1,263	1,263			

### Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Leeway, Inc	2167-C	9/30/2022	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	107,534	1,403			35,032	457
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	91,270	3,949			15,964	602
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers						
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	64,505	1,144			48,933	868
b. Other Maintenance Workers	30,921	1,183			23,457	897
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services	120,830	7,229			91,661	5,484
11. Accounting Services						
a. Head Accountant	80,277	1,414			26,153	460
b. Other Accountants	169,565	6,643			55,240	2,164
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	128,909	2,171				
b. RN						
1. Direct Care	494,673	10,589				
2. Administrative**	111,970	2,948				
c. LPN						
1. Direct Care	180,638	3,964				
2. Administrative**						
d. Aides and Attendants	539,639	24,541			339,957	15,893
e. Physical Therapists	131,621	2,715				
f. Speech Therapists	10,141	560				
g. Occupational Therapists	46,284	1,640	self-disallowed			
h. Recreation Workers	46,900	2,001			15,633	667
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	150,845	3,700			22,478	800
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	2,506,522	77,794			674,508	28,292

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

Name of Facility				License No.	Report for Year Ended				Page	of
Leeway, Inc				2167-C	9/30/2022				11	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Residential Care Home							
<b>Section I - Operators/Owners</b>										
<b>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).</b>										

\* 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.

**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	
Leeway, Inc				2167-C	9/30/2022			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Residential Care Home							
<b>Section III - Administrators***</b>										
Jay Katz	107,534		35,032	Standard	CEO	1,860	A.2		220	21,116
	Total Salary= \$142,566									
<b>Section IV - Assistant Administrators</b>										

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

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

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

**B. Report of Expenditures - Professional Fees**

Name of Facility	License No.	Report for Year Ended	Page	of		
Leeway, Inc	2167-C	9/30/2022	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian	6,017	100			5,980	100
2. Dentist						
3. Pharmacist	5,488	48				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	36,000	184				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)	13,832	96				
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	40,286	504				
2. Administrative***	12,800	160				
b. LPN						
1. Direct Care	90,943	1,300				
2. Administrative***						
c. Aides	51,549	1,031				
d. Other						
12. Other (Specify) See Attached Schedule						
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>256,915</b>	<b>3,423</b>			<b>5,980</b>	<b>100</b>

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

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

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

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

Name of Facility Leeway, Inc		License No. 2167-C	Report for Year Ended 9/30/2022	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Guardian Consulting Services	Pharmacy Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
Annunuddha Walallyadda, MD	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Yale School of Medicine	Staff Training /HIV AIDS Program Oversight	<input type="radio"/>	<input checked="" type="radio"/>		
Glendale	Dietician	<input type="radio"/>	<input checked="" type="radio"/>		
Lisa Meadows	MDS Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
Christine Regan	Nurse Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
AAA Nurse Staffing	RN, LPN & C.N.A staff	<input type="radio"/>	<input checked="" type="radio"/>		
Everything Nurse Staffing	RN, LPN & C.N.A staff	<input type="radio"/>	<input checked="" type="radio"/>		
Clipboard Nurse Staffing	RN, LPN & C.N.A staff	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		

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

**C. Expenditures Other Than Salaries - Administrative and General**

Name of Facility	License No.	Report for Year Ended		Page	of
Leeway, Inc	2167-C	9/30/2022		15	37
Item	Total	CCNH	RHNS	Residential Care Home	
<b>1. Administrative and General</b>					
<b>a. Employee Health &amp; Welfare Benefits</b>					
1. Workmen's Compensation	\$ 143,482	113,058			30,424
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 9,473	7,464			2,009
4. Social Security (F.I.C.A.)	\$ 227,933	179,602			48,331
5. Health Insurance	\$ 234,599	184,855			49,744
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 89,306	70,369			18,937
8. Uniform Allowance	\$ 2,568	2,023			545
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ (8,930)	(7,037)			(1,893)
<b>b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*</b>	\$				
<b>c. Bad Debts*</b>	\$ 58,100	44,583			13,517
<b>d. Accounting and Auditing</b>	\$ 37,830	28,534			9,296
<b>e. Legal (<i>Services should be fully described on Page 7</i>)</b>	\$ 5,008	3,777			1,231
<b>f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*</b>	\$				
<b>g. Office Supplies</b>	\$ 10,196	7,691			2,505
<b>h. Telephone and Cellular Phones</b>					
1. Telephone & Pagers	\$ 26,954	20,331			6,623
2. Cellular Phones	\$ 4,543	3,427			1,116
<b>i. Appraisal (<i>Specify purpose and attach copy</i>)*</b>	\$				
<b>j. Corporation Business Taxes (<i>franchise tax</i>)</b>	\$				
<b>k. Other Taxes (<i>Not related to property - See Page 22</i>)</b>					
1. Income*	\$				
2. Other ( <i>Specify</i> ) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 194,813	194,813			
<b>Subtotal</b>	\$ 1,035,875	853,490			182,385

\* 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**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>Residential Care Home</b>
Benefit Allocations to Grants & Housing	\$ (7,163)		\$ (1,927)
Employee Assistance Program	\$ 126		\$ 34
<b>Total</b>	\$ (7,037)	\$ -	\$ (1,893)

**Schedule of Other Taxes**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>Residential Care Home</b>
<b>Total</b>	\$ -	\$ -	\$ -

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

Name of Facility Leeway, Inc	License No. 2167-C	Report for Year Ended 9/30/2022		Page 16	of 37
Item	Total	CCNH	RHNS	Residential Care Home	
<b>Subtotals Brought Forward:</b>	1,035,875	853,490		182,385	
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 3,247	2,449		798	
3. Gifts to Staff and Residents	\$ 6,939	5,234		1,705	
4. Employee Travel	\$ 1,676	1,264		412	
5. Education Expenses Related to Seminars and Conventions	\$ 13,738	10,362		3,376	
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$ 8,286	6,250		2,036	
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$ 6,099	4,600		1,499	
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$				
4. Fund-Raising***	\$ 32,118	24,226		7,892	
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 5,674	4,280		1,394	
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 6,207	4,681		1,526	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 1,226	925		301	
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$ 199,557	150,521		49,036	
12. Administrative Management Services**	\$				
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 43,541	27,549		15,992	
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 1,364,183	1,095,831		268,352	

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

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

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

## Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	Residential Care Home
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -

## Schedule of Other Advertising

Description	CCNH	RHNS	Residential Care Home
<b>Total Other Advertising</b>	\$ -	\$ -	\$ -

## Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
Leading Age	\$ 3,785		\$ 1,233
ALTCFM	\$ 64		\$ 21
CARCH	\$ 415		\$ 135
Vendomate	\$ 207		\$ 68
Soc. For Human Res.	\$ 37		\$ 12
BJ	\$ 173		\$ 57
<b>Total Dues</b>	\$ 4,681	\$ -	\$ 1,526

## Schedule of Contributions

Description	CCNH	RHNS	Residential Care Home
<b>Total Contributions</b>	\$ -	\$ -	\$ -

## Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
New Hire - Dietary	\$ 2,489		\$ 811
New Employee Hire	\$ 9,572		\$ 3,119
Licenses & Fees	\$ 2,043		\$ 666
Bank Charges	\$ 4,641		\$ 1,512
Employee Service Awards	\$ 354		\$ 115
Health & Drug Screening	\$ 9,867		\$ 3,214
Employee Background Checks	\$ 3,713		\$ 1,210
Nursing Home Week Celebration	\$ 2,351		\$ 766
Office Supplies - Dietary	\$ 855		\$ 279
Computer Supplies & Minor Equ	\$ 962		\$ 314
Cable TV - Allowable	\$ 1,800		\$ 1,800
Board of Directors Expense	\$ 69		\$ 23
Self Disallowances:			
Cable TV	\$ 8,605		\$ 8,605
Penalties And Late Fees	\$ 10,189		\$ 3,319
Lobbying Expenses	\$ 10,183		\$ 3,317
Barber & Beauty	\$ 216		\$ 70
Credit Card Fees	\$ 528		\$ 172
Resident Personal Items	\$ 272		\$ 89
POD / Patient Training	\$ (523)		\$ (170)
Swap Expense	\$ (40,876)		\$ (13,317)
Non-Reimbursable	\$ 239		\$ 78
<b>Total Other Administrative and General</b>	\$ 27,549	\$ -	\$ 15,992

**Schedule C-1 - Management Services\***

Name of Facility Leeway, Inc	License No. 2167-C	Report for Year Ended 9/30/2022	Page of 17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #

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

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

Name of Facility Leeway, Inc		License No. 2167-C	Report for Year Ended 9/30/2022	Page 18	of 37
Item	Total	CCNH	RHNS	Residential Care Home	
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$ 209,930	105,294			104,636
2. Non-Food Supplies	\$ 31,900	16,000			15,900
3. Other (Specify) _____	\$ _____				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 575,386	288,594			286,792
c. Other (Specify) _____	\$ _____				
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 817,216</b>	<b>409,888</b>			<b>407,328</b>
2E. Dietary Questionnaire	Total	CCNH	RHNS	Residential Care Home	
F. Resident Meals: Total no. of meals served per day:*	180	90			90
G. Is cost of employee meals included in 2D?	<input checked="" type="radio"/> Yes	<input type="radio"/> No			
H. Did you receive revenue from employees?	<input checked="" type="radio"/> Yes	<input type="radio"/> No	If yes, specify amt.		\$3,544
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)					p. 30,
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K. Is any revenue collected from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
N. Is any revenue collected from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)					

\* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

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

Name of Facility Leeway, Inc		License No. 2167-C	Report for Year Ended 9/30/2022	Page 19	of 37
Item		Total	CCNH	RHNS	Residential Care Home
3. Laundry					
a. In-House Processing*		Lbs.			
1.	Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$			
2.	Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.			
		Amt. \$			
3.	Personal clothing of residents washed, ironed, and/or processed.***	Lbs.			
		Amt. \$	1,507	1,376	131
4.	Repair and/or purchase of linens.***	Lbs.			
		Amt. \$	28,676	26,385	2,291
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$			
c. Other (Specify)		\$			
<b>3D. Total Laundry Expenditures (3a + b + c)</b>		\$	<b>30,183</b>	<b>27,761</b>	<b>2,422</b>
<b>3E. Laundry Questionnaire</b>					
F.	Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
G.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
H.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
I.	Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
J.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
K.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

\* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3D.

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Leeway, Inc		2167-C	9/30/2022		20	37
Item			Total	CCNH	RHNS	Residential Care Home
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
	1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	31,491	27,389		4,102
b.	Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )	Sq. Ft. Serviced by Personnel				
		Amt. \$	308,545	191,969		116,576
C. Other ( <i>Specify</i> )		\$	5,754	3,272		2,482
<b>4D. Total Housekeeping Expenditures (4a + b + c)</b>		\$	345,790	222,630		123,160
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from	\$	189,070	189,070		
b.	Medicine Cabinet Drugs	\$	32,707	32,707		
c.	Medical and Therapeutic Supplies	\$	113,976	113,976		
d.	Ambulance/Limousine***	\$	255	255		
e.	Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	6,346	6,346		
f.	X-rays and Related Radiological Procedures***	\$	2,761	2,761		
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h.	Laboratory***	\$	16,913	16,913		
i.	Recreation	\$	2,997	2,248		749
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	15,030	12,315		2,715
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>		\$	380,055	376,591		3,464

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

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

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

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

**Schedule of Other Resident Care**

Description	CCNH	RHNS	Residential Care Home
Medical Equip - Title 19	\$ 3,605		
Medical Equip - Med A <span style="color: red;">self-disallowed 100%</span>	\$ 1,359		
Medical Equip - T19	\$ 1,468		
IV - T-19	\$ 1,488		
Wound Vac - Medicaid	\$ -		
Minor Equip & Furniture - Nursing	\$ 4,395		
RCH SUPPLIES	\$ -		\$ 2,715
<b>Total Other Resident Care</b>	\$ 12,315	\$ -	\$ 2,715

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

Name of Facility Leeway, Inc			License No. 2167-C	Report for Year Ended 9/30/2022	Page of 21   37					
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	Residential Care Home	Pg	Line
Glendale		<input type="radio"/>	<input checked="" type="radio"/>		Dietary	288,594		286,792	18	
Unitex Laundry Services		<input type="radio"/>	<input checked="" type="radio"/>		Laundry	26,385		2,291	19	
Diversified Building Services		<input type="radio"/>	<input checked="" type="radio"/>		Housekeeping	191,969		116,576	20	
Controlled Air		<input type="radio"/>	<input checked="" type="radio"/>		HVAC	6,546		4,966	22	
John's Refuse		<input type="radio"/>	<input checked="" type="radio"/>		Trash	5,825		4,418	22	
Connecticut Business Systems		<input type="radio"/>	<input checked="" type="radio"/>		Office Equip Maint	14,543		4,738	22	
Point Click Care		<input type="radio"/>	<input checked="" type="radio"/>		Software	26,431		8,611	16	
Creative Financial Staffing		<input type="radio"/>	<input checked="" type="radio"/>		Temp Acctg & Bookkeeping	62,463		20,349	16	
AOS, Inc.		<input type="radio"/>	<input checked="" type="radio"/>		Computer Server Admin	45,016		14,665	16	
Paylocity		<input type="radio"/>	<input checked="" type="radio"/>		Payroll Processing	14,010		4,564	16	
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

\* List all contracted services over \$10,000. Use additional sheets if necessary.

\*\* Refer to Page 4 for definition of related.

\*\*\* Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility Leeway, Inc	License No. 2167-C	Report for Year Ended 9/30/2022			Page 22	of 37
Item	Total	CCNH	RHNS	Residential Care Home		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 19,934	11,335			8,599	
b. Heat	\$ 35,547	20,213			15,334	
c. Light & Power	\$ 113,541	64,564			48,977	
d. Water	\$ 18,935	10,767			8,168	
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 785	446			339	
f. Other ( <i>itemize</i> )	\$ 105,311	64,846			40,465	
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	<b>\$ 294,053</b>	<b>172,171</b>			<b>121,882</b>	
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$ 20,394	11,597			8,797	
b. Building & Building Improvements	\$ 282,759	160,787			121,972	
c. Non-Movable Equipment	\$ 19,368	11,013			8,355	
d. Movable Equipment	\$ 75,110	42,711			32,399	
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$ 397,631</b>	<b>226,108</b>			<b>171,523</b>	
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$ 7,947	4,519			3,428	
c. Leasehold Improvements	\$					
d. Other ( <i>Specify</i> )	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	<b>\$ 7,947</b>	<b>4,519</b>			<b>3,428</b>	
9. Rental payments on leased real property less real estate taxes included in item 10b	\$					
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$ 42	24			18	
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$ 405,620</b>	<b>230,651</b>			<b>174,969</b>	

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

## Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	Residential Care Home
Purchased Service - Plumber	\$ 85		\$ 65
Purch Service - HVAC	\$ 6,546		\$ 4,966
Purchased Services - Electric	\$ 1,135		\$ 861
Purch Serv - Exterminator	\$ 1,260		\$ 955
Purchased Serv - Alarm Service	\$ 838		\$ 636
Purch Service - Fire Protecti	\$ 4,303		\$ 3,264
Purch Serv - Sec camera Main	\$ 2,749		\$ 2,085
Purch Service - Ridgefield As	\$ 4,777		\$ 3,623
Purch Service - Elevator	\$ 827		\$ 628
Purchased Service - Fire Cont	\$ 1,052		\$ 798
Purch Service - Telephone Rep	\$ 2,381		\$ 1,806
Purch Serv - Nurse Call System	\$ 1,182		\$ 897
Purchased Service - Shredding	\$ 2,114		\$ -
Purchased Service - Generator	\$ 2,465		\$ 1,870
Purch Serv - Snow Removal	\$ 2,411		\$ 1,829
Purch Service - Med Equip Ins	\$ 694		\$ 526
Purch Services - Legionella Rist Ass	\$ 3,543		\$ 2,687
Trash Removal- Maint	\$ 5,825		\$ 4,418
Medical Waste Removal	\$ 1,090		\$ -
Landscaping	\$ 5,026		\$ 3,813
Office Equip Maint Agreements	\$ 14,543		\$ 4,738
<b>Total Other Repairs and Maintenance</b>	<b>\$ 64,846</b>	<b>\$ -</b>	<b>\$ 40,465</b>

### Depreciation Schedule

Name of Facility Leeway, Inc			License No. 2167-C			Report for Year Ended 9/30/2022			Page 23	of 37		
Property Item			Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals		
<b>A. Land Improvements</b>												
1. Acquired prior to this report period			305,769		305,769	129,336	SL	Various	20,394			
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal										20,394		
<b>B. Building and Building Improvements</b>												
1. Acquired prior to this report period			8,105,578		8,105,578	4,381,457	SL	Various	282,603			
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)			4,670		4,760		SL	Various	156			
B-4. Subtotal										282,759		
<b>C. Non-Movable Equipment</b>												
1. Acquired prior to this report period			336,346		336,346	199,892	SL	Various	18,487			
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)			26,450		26,450		SL	Various	881			
C-4. Subtotal										19,368		
		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							
<b>D. Movable Equipment</b>												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.			x		4	2007	14,983	14,983	14,983	SL	5	
b.			x		8	2017	68,717	68,717	58,218	SL	6	10,499
c.					7	2022	6,500	6,500		SL	5	650
d.												
2. Movable Equipment												
a. Acquired prior to this report period							793,070	793,070	510,187	SL	Various	59,622
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative							92,581	92,581		SL	Various	4,339
d. Standard Resident										SL	Various	
e. Specialized Resident												
Total Acquired during this report period							92,581	92,581				4,339
D-3. Subtotal												75,110
<b>E. Total Depreciation</b>												397,631



## Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
<b>Additions:</b>					
10/25/2021	Goody's Snow Tractor Container	Administrative	\$ 6,350	10	\$ 318
11/12/2021	Goody's Snow Blowers	Administrative	\$ 2,670	10	\$ 134
10/21/2021	EBM IT Computers	Administrative	\$ 5,449	5	\$ 545
12/21/2021	McKesson Mattresses	Administrative	\$ 2,406	10	\$ 120
12/31/2021	Neteam Innovations - Vocera project	Administrative	\$ 21,500	10	\$ 1,075
3/3/2022	Vocera (enhanced communications project)	Administrative	\$ 7,075	10	\$ 354
5/17/2022	F&W Equipment Corp - Snow Blower Tractor	Administrative	\$ 24,642	10	\$ 1,232
7/31/2022	McKesson - Outdoor Furniture	Administrative	\$ 22,489	20	\$ 562
<b>Total additions for Movable Equipment</b>			\$ 92,581		\$ 4,339 *
<b>Deletions:</b>					
<b>Total deletions for Movable Equipment</b>			\$ -		\$ - **

\*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
<b>Additions:</b>				
<b>Total additions for Leasehold Improvement</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

### Amortization Schedule\*

Name of Facility Leeway, Inc			License No. 2167-C		Report for Year Ended 9/30/2022			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1. Financing Costs Key Bank #1	12	2014	15	20,361	13,737	SL		2,036	
2. Financing Costs Key Bank #2	12	2014	20	59,107	33,988	SL		5,911	
3.									
B-4. Subtotal									7,947
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
<b>D. Total Amortization</b>									7,947

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

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

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

Name of Facility Leeway, Inc	License No. 2167-C	Report for Year Ended 9/30/2022	Page 25	of 37	
<b>11. Property Questionnaire</b>					
<b>Part A</b>					
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> 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 <b>NOT</b> Original Owner, Date of Purchase					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	60				
6. Square Footage					
7. Acquisition Cost					
a. Land					
b. Building					
<b>Part B - Owner and Related Parties</b>		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)	Variable	Fixed			
b. Date Mortgage Obtained	12/28/16	12/28/16			
c. Interest Rate for the Cost Year		500.00%			
d. Term of Mortgage (number of years)	15	20			
e. Amount of Principal Borrowed					
f. Principal balance outstanding as of	224,701	2,306,563			
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>					
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					
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	

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

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

Name of Facility		License No.	Report for Year Ended			Page	of
Leeway, Inc		2167-C	9/30/2022			26	37
Item		Total	CCNH	RHNS	Residential Care Home		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$ 11,977	6,811			5,166	
Name of Lender		Rate					
Key Bank							
Address of Lender							
2. Second Mortgage		\$ 137,613	78,252			59,361	
Name of Lender		Rate					
Key Bank							
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. <b>Total Building Interest Expense</b> (A1 - A4 + B5)		\$ 149,590	85,063			64,527	

*(Carry Subtotals forward to next page)*

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

Name of Facility		License No.	Report for Year Ended		Page	of
Leeway, Inc		2167-C	9/30/2022		27	37
Item			Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:			149,590	85,063		64,527
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) Working Capital			4,011	2,281		1,730
13. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)			153,601	87,344		66,257
14. Insurance						
a. Insurance on Property (buildings only)			7,666	3,845		3,821
b. Insurance on Automobiles			9,586	4,808		4,778
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)			38,630	30,439		8,191
2. Fire and Extended Coverage						
3. Other (Specify)			32,564	25,659		6,905
14d. <b>Total Insurance Expenditures</b> (14a + b + c)			88,446	64,751		23,695
15. <b>Total All Expenditures</b> (A-13 thru C-14)			7,323,072	5,451,055		1,872,017

### D. Adjustments to Statement of Expenditures

Name of Facility Leeway, Inc				License No. 2167-C	Report for Year Ended 9/30/2022	Page 28	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$ 46,284	46,284		
4.			Other - See attached Schedule	\$			
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$ 58,100	44,583		13,517
10.			Accounting	\$			
10a.			Legal	\$			
11.			Telephone	\$ 3,125			3,125
12.			Cellular Telephone	\$ 3,823	1,917		1,906
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.			Unallowable Advertising *	\$			
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 32,118	24,226		7,892
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ (16,937)	(10,495)		(6,442)
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$ 3,554	1,778		1,776
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
<b>Subtotal (Items 1 - 26)</b>				\$ 130,067	108,293		21,774

\* 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.



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

Name of Facility			License No.	Report for Year Ended	Page	of	
Leeway, Inc			2167-C	9/30/2022	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward				\$ 130,067	108,293		21,774
<b>Page 20 - Resident Care Supplies***</b>							
27.			Prescription Drugs	\$ 189,070	189,070		
28.			Ambulance/Limousine	\$ 610	610		
29.			X-rays, etc	\$ 2,761	2,761		
30.			Laboratory	\$ 14,323	14,323		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 1,359	1,359		
<b>Page 22 - Maintenance and Property</b>							
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	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ 7,933			7,933
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 346,123	316,416		29,707

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

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
		Medical Equip - Med A	\$ 1,359		
<b>Total Other Ancillary Costs</b>			\$ 1,359	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
<b>Total Excess Movable Equipment Depreciation</b>			\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
<b>Total Other Property Adjustments</b>			\$ -	\$ -	\$ -



<b>Total Unallowable Building Interest</b>			\$ -	\$ -	\$ -

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**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended			Page	of
Leeway, Inc	2167-C	9/30/2022			30	37
Item	Total	CCNH	RHNS	Residential Care Home		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 6,368,922	4,638,935		1,729,987		
b. Medicaid Room and Board Contractual Allowance **	\$ (177,895)	(98,873)		(79,022)		
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 589,000	589,000				
b. Medicare Room and Board Contractual Allowance **	\$ 433,849	433,849				
4. a. Private-Pay Residents and Other	\$ 96,950	29,800		67,150		
b. Private-Pay Room and Board Contractual Allowance **	\$ 700	700				
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 227,234	227,234				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (215,687)	(215,687)				
c. Prescription Drugs - Non-Medicare	\$					
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
2. a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$ 124,087	124,087				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (96,694)	(96,694)				
c. Physical Therapy - Non-Medicare	\$ 48,332	48,332				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (47,904)	(47,904)				
4. a. Speech Therapy - Medicare	\$ 8,793	8,793				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (5,209)	(5,209)				
c. Speech Therapy - Non-Medicare	\$ 15,218	15,218				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (14,769)	(14,769)				
5. a. Occupational Therapy - Medicare	\$ 87,785	87,785				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (69,278)	(69,278)				
c. Occupational Therapy - Non-Medicare	\$ 38,514	38,514				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (38,426)	(38,426)				
6. a. Other ( <i>Specify</i> ) - Medicare	\$ 11,186	11,186				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$					
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 7,384,708	5,666,593		1,718,115		
<b>IV. Other Revenue*</b>						
1. Meals sold to guests, employees & others	\$ 3,544	1,778		1,766		
2. Rental of rooms to non-residents	\$					
3. Telephone	\$ 3,125			3,125		
4. Rental of Television and Cable Services	\$ 7,933			7,933		
5. Interest Income ( <i>Specify</i> )	\$ 301	151		150		
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$ 83,745	60,468		23,277		
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 98,648	62,397		36,251		
<b>VI. Total All Revenue</b> (III +V)	\$ 7,483,356	5,728,990		1,754,366		

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

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

**Schedule of Other Resident Revenue - Medicare**

Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
	Radiology-Medicare	\$ 1,750		
	Radiology Revenue Medicare Replacement	\$ 629		
	Lab- Medicare	\$ 5,953		
	Lab Revenue Medicare Replacement	\$ 2,854		
	<b>Total Other Resident Revenue - Medicare</b>	<b>\$ 11,186</b>	<b>\$ -</b>	<b>\$ -</b>

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

Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
	<b>Total Other Resident Revenue</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Interest Income**

Account

Page Ref	Account	Balance	CCNH	RHNS	Residential Care Home
	Money Market Account		\$ 151		\$ 150
	<b>Total Interest Income</b>		<b>\$ 151</b>	<b>\$ -</b>	<b>\$ 150</b>

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	Residential Care Home
	Misc. Revenue	\$ 243		\$ 79
	Brick Campaign	\$ 602		\$ 598
	Fund Raiser-Annual Appeal	\$ 4,105		\$ 4,080
	Donations - Unrestricted	\$ 55,495		\$ 18,498
	Donations - United Way	\$ 23		\$ 22
	<b>Total Other Revenue</b>	<b>\$ 60,468</b>	<b>\$ -</b>	<b>\$ 23,277</b>

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc	2167-C	9/30/2022	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	1,345,685
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	890,584
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	124,009
4. Inventories			\$	
5. Prepaid Expenses			\$	7,722
a. _____				
b. _____				
c. _____				
d. See Schedule		7,722		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	
_____				
_____				
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	2,368,000
B. Fixed Assets				
1. Land			\$	581,784
2. Land Improvements	*Historical Cost	305,769	\$	156,039
	Accum. Depreciation	149,730	Net	
3. Buildings	*Historical Cost	8,110,248	\$	3,446,032
	Accum. Depreciation	4,664,216	Net	
4. Leasehold Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____	Net	
5. Non-Movable Equipment	*Historical Cost	362,796	\$	143,536
	Accum. Depreciation	219,260	Net	
6. Movable Equipment	*Historical Cost	885,651	\$	311,503
	Accum. Depreciation	574,148	Net	
7. Motor Vehicles	*Historical Cost	90,200	\$	5,850
	Accum. Depreciation	84,350	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	2,079,452
_____				
See Schedule		2,079,452		
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	6,724,196

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

(Carry Total forward to next page)

## Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
		Prepaid Insurance	\$ 2,024
		Prepaid Dues	\$ 1,750
		Prepaid IT Support	\$ 680
		Prepaid Maintenance	\$ 3,268
		<b>Total Prepaid Expenses</b>	<b>\$ 7,722</b>

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

Page Ref	Line Ref	Description	
		<b>Total Other Current Assets (Itemize)</b>	<b>\$ -</b>

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

Page Ref	Line Ref	Description	
		Assets (Net of Depreciation) - Nonreimbursable	\$ 2,077,992
		CIP - Elevator	\$ 1,460
		<b>Total Other Other Fixed Assets (Itemize)</b>	<b>\$ 2,079,452</b>

## Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Board Designated Fund	\$ 302,053
		Deferred Financing Key Bank Mortgage	\$ 20,361
		Deferred Financing Key Bank Construction Mortgage	\$ 59,107
		Accumulatted Amortz Mortgage Financing	\$ (15,780)
		Accumulatted Amortz Mortgage Financing Construction	\$ (39,898)
		<b>Total Other Assets</b>	<b>\$ 325,843</b>

## Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
		<b>Total Notes Payable</b>	<b>\$ -</b>

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

Page Ref	Line Ref	Description	
		Resident Trust	\$ 49,432
		Accrued Provider Tax	\$ 53,391
		Deferred Income GNHCF	\$ 33,255
		Deferred Income DSS Grant	255781
		Medicaid Reserve	532719
		<b>Total Other Current Liabilities (Itemize)</b>	<b>\$ 924,578</b>

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

Page Ref	Line Ref	Description	
		Dss Bond Advance	\$ 975,000
		Mortgage SWAP Liability	\$ 5,088
		Construction Mortgage SWAP Liability	\$ 108,386
		<b>Total Other Current Liabilities (Itemize)</b>	<b>\$ 1,088,474</b>

### G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc	2167-C	9/30/2022	32	37
Account			Amount	
Total Brought Forward:			\$	9,092,196
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 <b>Total Leasehold or Like Properties</b> (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care ( <i>itemize</i> )			\$	
_____			\$	
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	
Name and Address	Amount	Loan Date		
7. Other Assets ( <i>itemize</i> )			\$	325,843
_____			\$	325,843
See Schedule			325,843	325,843
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	325,843
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$	9,418,039

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



### G. Balance Sheet (cont'd)

Name of Facility Leeway, Inc	License No. 2167-C	Report for Year Ended 9/30/2022		Page 34	of 37
Account				Amount	
Total Brought Forward:				1,361,924	
<b>Liabilities (cont'd)</b>					
B. Long-Term Liabilities					
1. Loans Payable-Equipment ( <i>itemize</i> )					
				\$	
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable				\$ 2,531,264	
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$	
Name and Address of Lender	Amount	Loan Date			
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$ 1,088,474	
See Schedule				1,088,474	
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 3,619,738	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 4,981,662	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Leeway, Inc	2167-C	9/30/2022	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
<b>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	4,141,801
6. Gain or Loss for Period	10/1/2021	thru 9/30/2022	\$	294,576
7. Total Net Worth			\$	4,436,377
<b>C. Total Reserves and Net Worth</b>			\$	4,436,377
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	9,418,039

### H. Changes in Total Net Worth

Name of Facility Leeway, Inc	License No. 2167-C	Report for Year Ended 9/30/2022	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2021			\$	
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$	
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$	
D. Net Income or Deficit			\$	
E. Balance			\$	
F. Additions				
1. Additional Capital Contributed ( <i>itemize</i> )				
2. Other ( <i>itemize</i> )				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )				
Name and Address ( <i>No., City, State, Zip</i> )		Title	Amount	
2. Other Withdrawings ( <i>Specify</i> )			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. <b>Balance at End of Period</b>			\$	
09/30/22				

### I. Preparer's/Reviewer's Certification

Name of Facility Leeway, Inc	License No. 2167-C	Report for Year Ended 9/30/2022	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> Residential Care Home		
<b>Preparer/Reviewer Certification</b>				
<p>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.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Address Address			Phone Number	
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number 203 865-0068	
Contact Email Address				