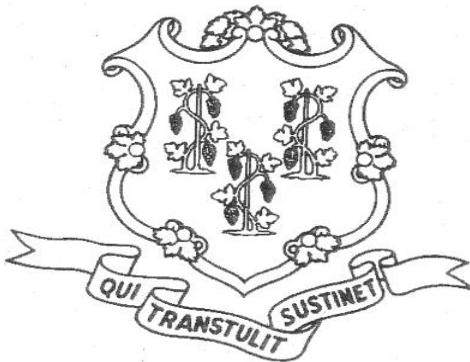


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2015

Name of Facility (as licensed) New Milford Crossings LLC DBA Village Crest Center for Health and Rehabilitation	
Address (No. & Street, City, State, Zip Code) 19 Poplar St., New Milford, CT 06776	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH 8771	RHNS	(Specify)	Medicare Provider 075208
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Medicaid Provider Numbers:	CCNH	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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
New Milford Crossings, LLC DBA Village Crest Cent	8771	9/30/2015	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 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 Bloomfield Health [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

New Milford Crossings, LLC

Signed (Administrator)		Date	Signed (Owner)		Date
<i>Richard Dimeola</i>		<i>2/09/16</i>	<i>[Signature]</i>		<i>2/11/16</i>
Printed Name (Administrator) Richard Dimeola			Printed Name (Owner) Marvin Ostreicher		
Subscribed and Sworn to before me:	State of <i>NY</i>	Date	Signed (Notary Public)	Comm. Expires	
			<i>Barbara J. Balioni</i>	<i>04/31/19</i>	
Address of Notary Public					
NATIONAL HEALTH CARE ASSOCIATES 46 Staudeman Avenue Lynbrook, New York 11563					

(Notary Seal)

BARBARA J. BALIONI
 NOTARY PUBLIC, State of New York
 No. 01BA5076583
 Qualified in Nassau County
 Commission Expires April 21, 2019

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility New Milford Crossings LLC DBA Village Crest Center for Health and Rehabilitation		Period Covered:	From 10/1/2014	To 9/30/2015
Address of Facility 19 Poplar St., New Milford, CT 06776				
Report Prepared By Blum Shapiro & Co.		Phone Number 860-561-4000	Date 2/8/2016	
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.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-354-9365		Report for Year Ended 9/30/2015	Page 2	of 37
Name of Facility (as shown on license) New Milford Crossings LLC DBA Village Crest Center for He		Address (No. & Street, City, State, Zip) 19 Poplar St., New Milford, CT 06776		
License Numbers:	CCNH 8771	RHNS	(Specify)	Medicare Provider No. 075208
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 type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input 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.				
Administrator				
Name of Administrator Richard A. Dimeola		Nursing Home Administrator's License No.:	000504	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

New Milford Crossings, LLC
Page 3 Attachment

Owner	Ownership Percentage
Agnes Zitter	2.083%
Albert David	1.667%
Barry Bokow	1.000%
BNB Healthcare Funds LLC	6.667%
Chaim Goldenberg	5.000%
David Cohen	6.667%
Gerald Neuman	3.333%
Ira Geffner	1.000%
Josef Skoczylas	2.000%
Tzivy Roberts	6.667%
Magda Manela	5.000%
Marvin J. Ostreicher	30.749%
Michael Lipman	5.000%
Mordechai Eisen	2.500%
Morris Fuchs	8.333%
Moshe Shaya-Mograby	1.667%
Nathan Pollack	4.167%
Shmuel Rubenstein	2.500%
Tali Skoczylas	4.000%
	<hr/>
	100.000%

General Information and Questionnaire Related Parties*

Name of Facility New Milford Crossings LLC DBA Village Crest Center	License No. 8771	Report for Year Ended 9/30/2015	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	%**				
See attachment.		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					

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

**General Information and Questionnaire
Related Parties***

Name of Facility New Milford Crossings LLC DBA Village Crest Center for Health and Rehabilitation	License No. 8771	Report for Year Ended 9/30/2015	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	%**				
Preferred Therapy	850 Silas Deane Hwy, Wethersfield, Ct 06109	<input checked="" type="checkbox"/>	<input type="checkbox"/>	26%	PT,OT,ST Services/Consulting	Page 13 5a,9a,10a,12B	672,693	639,568
NOA Diagnostics	6851 Jericho Turnpike, Suite 150 Syosset, NY 11791	<input checked="" type="checkbox"/>	<input type="checkbox"/>	79%	Radiology	Page 20 5f	8,127	7,464
National Health Care Associates - Aetna	151 Farmington Avenue Hartford, CT 06156	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Health Insurance Trust***	Page 15 1a5	451,613	451,613
Marlborough Health Care	85 Stage Harbor Rd, Marlborough, Ct 06447	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Bank Charges	Page 16 13	3,182	3,182
National Healthcare Associates	46 Stauderman Ave Lynbrook, NY 11563	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Banking Transactions	Page 16 13	13,142	13,142
EP New Milford Realty LLC	850 Silas Deane Hwy, Wethersfield, Ct 06109	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Rent	Page 22 9,10	363,000	363,000
National Health Care Associates	46 Stauderman Ave, Lynbrook, NY 11563	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Shared Expenses	Page 16 12	340,258	340,258
850 Silas Deane Realty	850 Silas Deane Hwy, Wethersfield, Ct 06109	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Rent/ Other Expenses	Page 16 12	1,249	1,249
Stauderman Realty	46 Stauderman Ave, Lynbrook, NY 11563	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Shared Expenses	Page 16 12	3,881	3,881
Procure LTC Pharmacy of CT	1492 Highland Ave Cheshire CT 06410	<input checked="" type="checkbox"/>	<input type="checkbox"/>	83%	Drugs/Otc's/Supplies/Consult/Med Records	Pages 20;13 5a2/b/c; B12	256,828	241,045

* Use additional sheets if necessary.

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

*** Consolidated for all National Healthcare CT Facilities, control and ownership pass upon transfer of funds to insurance company manager. Information required by previous state auditor.

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility New Milford Crossings LLC DBA Village Cres	License No. 8771	Report for Year Ended 9/30/2015	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.

Shared expenses, allocated by bed size. See page 17 attachment.

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

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
New Milford Crossings LLC DBA Village Crest Center for			8771	9/30/2015			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						
Reliable Health Systems, 2610 Nostrand Ave Brooklyn, NY 11210	<input type="radio"/>	<input checked="" type="radio"/>	Computer Equipment	03/01/08	Ongoing	14,954		14,954
CIT Finance LLC, 10201 Centurion Parkway N.#100 Jacksonville FL 32256	<input type="radio"/>	<input checked="" type="radio"/>	Copier	05/14/12	39 months	5,467		4,556
CIT Finance LLC, 10201 Centurion Parkway N.#100 Jacksonville FL 32256	<input type="radio"/>	<input checked="" type="radio"/>	Copier	07/21/15	39 months	4,998		833
Wells Fargo, 300 Tri State International Lincolnshire, IL 60069	<input type="radio"/>	<input checked="" type="radio"/>	Copier	06/26/13	39 months	3,697		3,697
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
							Total ***	24,040

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.



Lease Agreement

This Lease Agreement (the "Lease") contains the terms of your agreement with us. Please read it carefully and ask us any questions you may have. The words you, your and lessee mean you, our customer. The words we, us, our and the lessor, mean CIT Finance LLC.

Equipment Description

Quantity	Description	Equipment Address
1	TOSHIBA / ES757 /	19 POPLAR STREET, NEW MILFORD, CT 06776
1	TOSHIBA / ES 357 /	19 POPLAR STREET, NEW MILFORD, CT 06776

Supplier Name and Address: The Office Works, 45 Corporate Ave, Plainville, CT 06062

End of Lease Purchase Option

Fair Market Value

Term and Lease

Lease Payment **\$391.59** (plus taxes, if applicable)

Term (Months) **39**

Payment Frequency **MONTHLY**

Variable Payment Schedule if applicable:

Lease Payments are due in **Arrears**

The following additional payments are due on the date you sign this agreement:

One-time Documentation Fee **\$75.00** Payable with First Invoice
Advanced Payment **\$0.00** due at lease signing
(plus taxes, if applicable)

If more than one Lease Payment is required in advance, the additional amount will be applied at the end of the initial or any renewal term.

IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING A NEW ACCOUNT: To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. What this means for you: When you open an account, we will ask for (i) if you are a legal entity, your name, address, and other information that will allow us to identify you; (ii) if you are an individual, your name, address, and date of birth. We may also ask to see your driver's license or other identifying documents.

Lessee

VILLAGE CREST CENTER FOR HEALTH AND REHABILITATION

Lessee Legal Name

Lessee "Doing Business As" Name

19 POPLAR STREET

Billing Street Address

NEW MILFORD, CT 06776

Billing City, State, Zip

Billing Contact Name & Phone No.

860-354-9365

Lessee Phone Number (if different from above)

TERMS AND CONDITIONS BY SIGNING THIS LEASE:

(i) You acknowledge that you have read and understand the terms and conditions of this Lease including those on page 2 of this Lease; (ii) You agree that this Lease is a net lease that you cannot terminate or cancel, you have an unconditional obligation to make all payments due under this Lease, and you cannot withhold, set off or reduce such payments for any reason; (iii) You will use the Equipment only for business purposes; and (iv) You agree that by providing a telephone number to a cellular or other wireless device, you are expressly consenting to receiving communications from us, our affiliates and agents (for non-marketing purposes) at that number, including, but not limited to, prerecorded and artificial voice messages, text messages, and calls from automated telephone dialing systems; these calls may incur fees from your cellular provider; and this consent applies to each such telephone number you provide to us now or in the future.

ELECTRONIC TRANSMISSION AND COUNTERPARTS. A fax or electronically transmitted signed version of this Lease, when received by us, shall be binding on you for all purposes as if originally signed. This Lease is not binding on us until we sign it. We may accept this Lease by signing, either manually or electronically. You agree that the only version of this Lease that is the original for all purposes is the version containing your fax or scanned signature and our signature. This Lease may be signed in counterparts each of which will be considered an original and all counterparts will be considered and constitute one and the same Lease. This Lease may be retained electronically and you agree that any such electronic version shall be fully enforceable without the need to produce an original; however we may request an original signature document.

LESSOR: CIT Finance LLC
10201 Centurion Parkway N. #100
Jacksonville, FL 32256

Authorized Signature

Printed Name

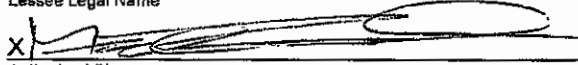
Print Title

Date Signed

LESSEE SIGNATURE

VILLAGE CREST CENTER FOR HEALTH AND REHABILITATION

Lessee Legal Name

X 

Authorized Signature

X **Michael Bokaw**

Print Signer's Name

X **Materials Management Coordinator**

Signer's Title

X **208720412**

Federal Tax ID Number

X **7/6/15**

Date Signed

1. LEASE; DELIVERY AND ACCEPTANCE. You agree to lease the equipment described on the front of this lease agreement ("Lease") ("Equipment") on the terms and conditions shown on the front and back of this lease. You agree to pay the Documentation Fee with your first invoice and the Advanced Payment when you sign this lease. You will arrange for the delivery of the Equipment to you. When you receive the Equipment, you agree to inspect it to determine if it is in good working order. This Lease will begin on the date you accept the Equipment. The Equipment will be deemed irrevocably accepted by you upon the earlier of (a) the delivery to us of a signed Delivery and Acceptance Certificate (if requested by us); or (b) 10 days after delivery of the Equipment to you if you previously have not given written notice to us of your non-acceptance. The first Lease Payment is due on or after the date you accept the Equipment. If you accept the Equipment in accordance with this Section 1, the remaining Lease Payments will be due on the day of each subsequent month (or such other time period stated on the front of this Lease) specified by us. You will make all payments required under this Lease to us at such address as we may specify in writing. You authorize us to adjust the Lease Payment by not more than 15% if the actual Total Cash Price (which is all amounts we have paid in connection with the purchase, delivery and installation of the Equipment, including any trade-up and buyout amounts) differs from the estimated Total Cash Price. If any Lease Payment or other amount payable to us is not paid within 10 days of its due date, you will pay us a late charge not to exceed 7% of each late payment, (but in no event greater than maximum rate allowable under applicable law).

2. NO WARRANTIES. We are leasing the Equipment to you "AS-IS". YOU ACKNOWLEDGE THAT WE DO NOT MANUFACTURE THE EQUIPMENT, WE DO NOT REPRESENT THE MANUFACTURER OR THE SUPPLIER, AND YOU HAVE SELECTED THE EQUIPMENT AND SUPPLIER BASED UPON YOUR OWN JUDGMENT. WE MAKE NO WARRANTIES, EXPRESS OR IMPLIED, INCLUDING WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE OR OTHERWISE. YOU AGREE THAT REGARDLESS OF CAUSE, WE ARE NOT RESPONSIBLE FOR AND YOU WILL NOT MAKE ANY CLAIM AGAINST US FOR ANY DAMAGES, WHETHER CONSEQUENTIAL, DIRECT, SPECIAL, OR INDIRECT. YOU AGREE THAT NEITHER SUPPLIER NOR ANY SALESPERSON, EMPLOYEE OR AGENT OF SUPPLIER IS OUR AGENT OR HAS ANY AUTHORITY TO SPEAK FOR US OR TO BIND US IN ANY WAY. To the extent transferable, we transfer to you for the term of this Lease any warranties made by the manufacturer or Supplier under a purchase contract.

3. EQUIPMENT LOCATION; USE AND REPAIR; RETURN. You may not move the Equipment without our prior written consent, not to be unreasonably withheld. If we consent to a move, you agree that you will be liable for any increase in personal property taxes as a result of that relocation. At your own cost and expense, you will keep the Equipment eligible for any manufacturer's certification, in compliance with all applicable laws and in good condition, except for ordinary wear and tear. You will not make any alterations, additions or replacements to the Equipment without our prior written consent. All alterations, additions and replacements will become part of the Equipment and our property at no cost or expense to us. We may inspect the Equipment at any reasonable time after advance notice to you. Unless you purchase the Equipment in accordance with a purchase option granted to you on the first page of this Lease, within 10 days of the expiration of this Lease, you will immediately deliver the Equipment to us in good condition and repair, except for ordinary wear and tear, to any place in the United States that we direct you in our return authorization in as good condition as when you received it, except for ordinary wear and tear. You will pay for all outstanding lease payments, late charges, insurance charges, and our estimated property taxes on the Equipment based upon the prior year's actual property tax, and expenses of disinstalling, crating, shipping, and insuring the Equipment for its full replacement value during shipping. Unless we request return to us, you must retain physical possession of the Equipment through the end of the initial or any renewal lease term.

4. TAXES AND FEES. You are responsible for all sales and use (unless you provide us with an acceptable Sales/Use Tax exemption form), personal property or other taxes relating to the use or ownership of the Equipment, now or hereafter imposed, or assessed by any state, federal or local government or agency. You agree to pay when due, or reimburse us for all taxes, fines or penalties imposed upon the Equipment and, if we elect, you agree to pay us estimated property taxes either with each lease payment or at the end of the lease term as more fully set forth herein. We will file all sales, use and personal property tax returns (unless we notify you otherwise in writing). We do not have to contest any taxes, fines or penalties; however, you may do so provided (a) you do so in your own name and at your expense, (b) the contest will not result in any sort of lien being placed on the Equipment or otherwise jeopardize our rights in any of the Equipment, (c) you pay us for any taxes we are remitted to the taxing authorities even though you may be contesting the taxes and indemnify and hold us harmless for any expenses, including legal expenses, we incur as a result of such contest. If we file such personal property tax reports, you will pay property taxes as invoiced by us.

5. LOSS OR DAMAGE. As between you and us, you are responsible for any loss, theft or destruction of, or damage to the Equipment (collectively "Loss") from any cause at all, whether or not insured, until it is delivered to us at the end of this Lease. You are required to make all Lease Payments even if there is a Loss. You must notify us in writing immediately of any Loss. Then, at our option, you will either (a) repair the Equipment so that it is in good condition and working order, eligible for any manufacturer's certification, or (b) pay us the amounts specified in Section 9(b) below.

6. INSURANCE. You are responsible for installing and keeping the Equipment in good working order. Except for ordinary wear and tear, you are responsible for protecting the Equipment from damage and loss of any kind. If the Equipment is damaged or lost, you agree to continue to pay the amounts due and to become due hereunder without setoff or defense. During the term of this Agreement, you agree that you will (1) insure the equipment against all loss or damage naming us as loss payee; (2) obtain liability and third party property damage insurance naming us as an additional insured; and (3) deliver satisfactory evidence of such coverage with carriers, policy forms and amounts acceptable to us. All policies must provide that we be given thirty (30) days written notice of any material change or cancellation. If you do not provide evidence of acceptable insurance, we have the right, but no obligation, to obtain insurance covering our interest in the Equipment for the lease term, and renewals. Any insurance we obtain will not insure you against third party or liability claims and may be canceled by us at any time. In the event we obtain the above-described insurance, you will be required to pay us an additional amount each month for the insurance premium and an administrative fee. You agree that we, or one of our affiliates, may make a profit in connection with the insurance we obtain. The cost may be more than the cost of obtaining your own insurance. You agree to cooperate with us, our insurer and our agent in the placement of coverage and with claims. If you later provide us with evidence that you have obtained acceptable insurance, we will cancel the insurance we obtained. The insurance we obtain (1) will not name you as an insured, additional insured, or loss payee; (2) will not provide you with liability insurance; (3) may not pay any claim that you make; (4) will not pay any claim made against you; and (5) may be cancelled by us at any time.

7. TITLE; RECORDING. Unless you are given a \$1.00 purchase option, we are the owner of and will hold title to the Equipment. However, if you are given a \$1.00 purchase option, you agree that this transaction is a lease intended for security, and you grant us a security interest in the Equipment (including any replacements, substitutions, additions, attachments and proceeds). You will keep the Equipment free of all liens and encumbrances. YOU AUTHORIZE US TO FILE FINANCING STATEMENTS COVERING THE EQUIPMENT.

8. DEFAULT. Each of the following is a "Default" under this Lease: (a) you fail to pay any Lease Payment or any other payment within 30 days of its due date; (b) you do not perform any of your other obligations under this Lease or in any other agreement with us or with any of our affiliates and this failure continues for 30 days after we have notified you of it; (c) you become insolvent, you dissolve, you assign your assets for the benefit of your creditors, you sell, transfer or otherwise dispose of all or substantially all of your assets, or you enter (voluntarily or involuntarily) any bankruptcy or reorganization proceeding; (d) without our prior written consent, which will not be unreasonably withheld or delayed, you merge or consolidate with any other entity and you are not the survivor of such merger or consolidation; or (e) any guarantor of this Lease dies, does not perform its obligations under the guaranty, or becomes subject to one of the events listed in clause (a) of this Section 8.

9. REMEDIES. If a Default occurs, we may do one or more of the following: (a) we may cancel or terminate this Lease and any or all other agreements that we have entered into with you; (b) we may require you to immediately pay us, as compensation for loss of our bargain and not as a penalty, a sum equal to (i) the present value of all unpaid Lease Payments for the remainder of the term plus, the present value of our anticipated residual interest in

the Equipment, each discounted at the lesser of (1) the rate implicit in the Lease, or (2) 4% per year, plus (ii) past due interest at the rate of 18% per annum, plus (iii) all other amounts due and to become due under this Lease, (c) we may require you to deliver the Equipment to us as set forth in Section 3; (d) we or our agent may peacefully repossess the Equipment without court order and you will not make any claims against us for damages or trespass or any other reason; and (e) we may exercise any other right or remedy available at law or in equity. In the event of a dispute arising out of this Lease, the prevailing party shall be entitled to its reasonable collection costs and attorney fees and costs incurred in enforcing or defending this Lease. If we take possession of the Equipment, we may sell or otherwise dispose of it with or without notice, at a public or private sale, and apply the net proceeds (after we have deducted all costs related to the sale or disposition of the Equipment) to the amounts that you owe us. You will remain responsible for any amounts that are due after we have applied such net proceeds. You agree that if notice of sale is required by law to be given, 10 days notice shall constitute reasonable notice. If we delay or fail to enforce any of our rights under this Lease, we will still be entitled to enforce those rights at a later time.

10. FINANCE LEASE STATUS. You agree that if Article 2A-Leases of the Uniform Commercial Code applies to this Lease, this Lease will be considered a "finance lease" as that term is defined in Article 2A. By signing this Lease, you agree that either (a) you have reviewed, approved, and received a copy of the purchase contract or (b) that we have informed you of the identity of the Supplier, that you may have rights under the purchase contract, and that you may contact the supplier for a description of those rights. TO THE EXTENT PERMITTED BY APPLICABLE LAW, YOU WAIVE ANY AND ALL RIGHTS AND REMEDIES CONFERRED UPON A LESSEE BY ARTICLE 2A.

11. ASSIGNMENT; YOU MAY NOT ASSIGN, SELL, TRANSFER OR SUBLEASE THE EQUIPMENT OR YOUR INTEREST IN THIS LEASE, WITHOUT OUR PRIOR WRITTEN CONSENT, WHICH CONSENT WILL NOT BE UNREASONABLY WITHHELD. We may, without notifying you, sell, assign, or transfer this Lease and our rights in the Equipment. You agree that the new owner will have the same rights and benefits that we have now under this Lease but not our obligations, which we will remain responsible for. The rights of the new owner will not be subject to any claim, defense or set-off that you may have against us or the supplier.

12. PURCHASE OPTION; AUTOMATIC RENEWAL. If no Default has occurred and is continuing under this Lease, you will have the option at the end of the initial or any renewal term to purchase all (but not less than all) of the Equipment at the Purchase Option price shown on the front of this Lease, plus any applicable taxes and if the purchase occurs after the rendition date for any personal property taxes on the Equipment you agree to pay us the estimated property tax based upon the prior year's actual property tax. Unless the Purchase Option price is \$1, you must give us at least 90 days but no more than 180 days written notice before the end of the initial lease term, or 30 days prior to the end of any renewal term, that you will either purchase or return the Equipment to us. If you do not give us such written notice or, having given such notice, if you do not purchase or deliver the Equipment in accordance with the terms of this Lease, this Lease will automatically renew for an initial 3 month renewal term and thereafter for successive one month terms unless and until you give us the 30 day notice and either purchase or deliver the Equipment to us. Each month during such renewal term(s) the Lease Payment will remain the same. If your payment frequency is monthly your payments during renewal remain the same. If your payment frequency is other than monthly, then your renewal payments shall be the monthly equivalent of your periodic payment amount. We may cancel an automatic renewal term by sending you 10 days prior written notice. If the Fair Market Value Purchase Option has been selected, we will use our reasonable judgment to determine the Equipment's Fair Market Value as configured, in place, and installed. You agree that Fair Market Value is the amount that may reasonably be expected for the installed Equipment in an exchange between a willing buyer and a willing seller, including costs to make the Equipment fully operational. If you do not agree with our determination of the Equipment's Fair Market Value, the Fair Market Value will be determined at your expense by an independent appraiser mutually acceptable to you and us. Upon payment of the Purchase Option price, we shall transfer our interest in the Equipment to you "AS-IS, WHERE-IS" without any representation or warranty whatsoever and this Lease will terminate.

13. INDEMNIFICATION. You are responsible for any losses, damages, penalties, claims, suits and actions (collectively "Claims"), whether based on a theory of strict liability or otherwise caused by or related to or in any manner arising from the Equipment. You agree to reimburse us for and if we request, to defend us against, any Claims, except Claims caused by our willful misconduct. You agree that your obligations under this Section 13 and Section 4 shall survive the termination of this Lease for Claims arising during the term of this Lease.

14. CREDIT INFORMATION; FINANCIAL STATEMENTS. YOU AUTHORIZE US OR ANY OF OUR AFFILIATES TO OBTAIN CREDIT BUREAU REPORTS, AND MAKE OTHER CREDIT INQUIRIES THAT WE DETERMINE ARE NECESSARY. You agree to provide us copies of your balance sheet, income statement and other financial reports as we may reasonably request.

15. SOFTWARE. The Products provided hereunder may include certain Software Imbedded, or loaded on the Equipment, that you agree to use consistent with the underlying software license granted to you under your purchase contract. You acknowledge that such Software enhances the value of the Products. Where required by the Software owner, you agree to execute a separate license agreement with the owner for the use of the Software ("License Agreement"). We do not have any obligations under the License Agreement. However, you have granted us certain rights under this Lease on the software is loaded and agree to not remove any software without our written consent. Except as expressly modified by this Section 15, all the terms and conditions of this Lease shall apply to the Software including, without limitation, Section 2.

16. DATA SECURITY. Some or all of the items of Equipment returned to us at any time may contain sensitive information or data belonging to your organization, or your customer/clients/patients, that is stored, recorded, or in any way contained within or on the Equipment. You specifically agree that before the Equipment is shipped to or retrieved by us or our agents, or removed by a supplier, you will, at your sole cost and expense, permanently destroy, delete and remove all such information and data that is stored, recorded or in any way contained within or on the Equipment, to the extent that further recovery of any of such data and information is not possible. You have the sole responsibility to so destroy, delete, and remove all data and information stored in or on the Equipment. We have absolutely no liability for any data or information that you fail to so destroy, delete, and remove. All hard drives and other data retention components must function as originally installed after data removal.

17. MISCELLANEOUS. (a) Choice of Law. This Lease shall be governed by the laws of the State of Utah (without regard to the conflict of laws principles of such state). (b) Jury Trial. YOU EXPRESSLY WAIVE TRIAL BY JURY AS TO ALL ISSUES ARISING OUT OF OR RELATED TO THIS LEASE. (c) Entire Agreement. The Lease constitutes the entire agreement between you and us and supersedes all prior agreements. (d) Enforceability. If any provision of this Lease is unenforceable, illegal or invalid, the remaining provisions shall continue to be effective. (e) Amendment. This Lease may not be modified or amended except by a writing signed by you and us, either manually or electronically. You agree however, that we are authorized, without notice to you, to supply missing information or correct obvious errors in the Lease, such as serial numbers, or correct typographical, immaterial, or obvious errors in this Lease provided that such change does not materially alter your obligations under this Lease. (f) Notice. All notices shall be in writing and shall be delivered to the appropriate party personally, by private courier, by facsimile transmission, or by mail, postage prepaid, at its address shown herein or to such other address as directed in writing by such party. (g) Usury. It is the express intent of both of us not to violate any applicable usury laws or to exceed the maximum amount of interest permitted to be charged or collected by applicable law, and any thereafter excess payment will be applied to the Lease Payments in inverse order of maturity, and any remaining excess will be refunded to you. (h) Prepayment. Prepayment or early termination is not permitted except at such time and on such terms and conditions as Lessor may agree in writing. (i) NSF. We may also charge you \$25.00 for each returned check or if an ACH debit is not honored by your bank. (j) Restrictive Endorsements. You agree that any restrictive endorsement (such as "payment in full", "final payment" or otherwise) on any check submitted in payment for this Lease shall have no force and effect and that we may cash the check and apply the proceeds without issued by you in conjunction with this Lease are issued solely for your administrative purposes prejudice to our rights under this Lease. (k) Purchase Orders. You agree that any purchase orders and no terms or conditions contained in the purchase order will change or modify the terms and conditions of this Lease.

General Information and Questionnaire Accounting Basis

Name of Facility New Milford Crossings LLC DBA	License No. 8771	Report for Year Ended 9/30/2015	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 1 Blum Shapiro & Co 2 3 4	Address (No. & Street, City, State, Zip Code) 29 S. Main St., West Hartford, CT 06127
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Services Provided by This Firm (*describe fully*)

1 Review, preparation of Medicare and Medicaid cost reports, and year end tax services	\$	25,600
2	\$	
3	\$	
4	\$	
Charge for Services Provided		
\$		25,600

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

- Yes No Page 15, line d

Legal Services Information

Name of Legal Firm or Independent Attorney 1 Berchem, Moses & Devlin, PC 2 Suzanne Corbett 3 Goldman Gruder & Wood 4 Treasurer, State of CT 5	Telephone Number (203) 783-1200 (860) 354-9077 (203) 899-8900 Ext. 0000
--	--

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

- 1 75 Broad Street Milford, CT 06460
 2 3 Mulberry Lane New Milford, CT 06776
 3 200 Connecticut Avenue, Norwalk, CT 06854
 4 55 Elm Street #2, Hartford, CT, 06106
 5

Services Provided by This Firm (*describe fully*)

1 Labor	\$	9,001
2 Conservator	\$	50
3 Collections	\$	8,334
4 Conservator	\$	450
5	\$	
Charge for Services Provided		
\$		17,835

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

- Yes No Page 15, line 1e

Schedule of Resident Statistics

Name of Facility			License No.		Report for Year Ended				Page	of			
New Milford Crossings LLC DBA Village Crest Center for Health and R			8771		9/30/2015				8	37			
	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	95	95			95	95			95	95			
B. On last day of THIS report period	95	95			95	95			95	95			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	79	79			79	79			74	74			
B. As of midnight of THIS report period	76	76			74	74			76	76			
3. Total Number of Days Care Provided During Period													
A. Medicare	5,125	5,125			3,937	3,937			1,188	1,188			
B. Medicaid (Conn.)	21,538	21,538			16,002	16,002			5,536	5,536			
C. Medicaid (other states)													
D. Private Pay	2,447	2,447			1,965	1,965			482	482			
E. State SSI for RCH													
F. Other (Specify)	590	590			579	579			11	11			
G. Total Care Days During Period (3A thru F)	29,700	29,700			22,483	22,483			7,217	7,217			
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	8	8			4	4			4	4			
5. Total Resident Days (3G + 4A + 4B)	29,708	29,708			22,487	22,487			7,221	7,221			

2015 Cost Report - Page 8 attachment

Page 8, Line 3F: Total Number of Other Days Care Provided During the Period

Managed Care	<u>370</u>
Hospice	<u>220</u>
VA	<u>-</u>

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Schedule of Resident Statistics (Cont'd)

Name of Facility New Milford Crossings LLC DBA Village C			License No. 8771			Report for Year Ended 9/30/2015			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	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days								CCNH	RHNS	(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	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	9		59		8								
Per Diem Rate													
a. One bed rm.	PPS		226.70		408/463								
b. Two bed rms.	PPS		226.70		378/433								
c. Three or more bed rms.	PPS		226.70		343/390								
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								2,537	2,537				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								232	232				
C. Other								17,141	17,141				
D. Total Physical Therapy Treatments								19,910	19,910				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								342	342				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								24	24				
C. Other								696	696				
D. Total Speech Therapy Treatments								1,062	1,062				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								1,352	1,352				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								195	195				
C. Other								14,142	14,142				
D. Total Occupational Therapy Treatments								15,689	15,689				

Report of Expenditures - Salaries & Wages

Name of Facility New Milford Crossings LLC DBA Village Crest Center for I	License No. 8771	Report for Year Ended 9/30/2015	Page 10	of 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	(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)	131,149	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	169,301	10,284				
5. Dietary Service						
a. Head Dietitian	32,868	831				
b. Food Service Supervisor	63,040	2,360				
c. Dietary Workers	253,829	18,831				
6. Housekeeping Service						
a. Head Housekeeper	51,497	2,080				
b. Other Housekeeping Workers	176,166	14,098				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	52,249	1,889				
b. Other Maintenance Workers	66,122	3,576				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	63,574	5,617				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	114,653	2,435				
b. RN						
1. Direct Care	519,960	13,689				
2. Administrative**	81,441	2,208				
c. LPN						
1. Direct Care	934,251	34,566				
2. Administrative**						
d. Aides and Attendants	978,844	68,540				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	97,030	5,290				
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	133,636	4,295				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	3,919,610	192,668				

* 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	
New Milford Crossings LLC DBA Village Crest Center for Health an				8771	9/30/2015			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	(Specify)							
Section I - Operators/Owners										
Marvin J. Ostreicher, 184 Wildacre Ave, Lawrence, NY 11559				same as employees	Supervises operations, deals with DNS & other patient care,	48	Page 16,1m1	See attached		
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.

MARVIN J. OSTREICHER
TIME STUDY
Y/E SEPTEMBER 2015

	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	TOTAL
Augusta	3.00	8.50	7.00	4.00	7.50	7.50	1.50	4.50	7.50	5.50	4.50	6.50	67.50
Belair	5.00	5.50	7.00	3.00	5.50	4.50	2.50	2.00	3.00	5.00	6.50	5.00	54.50
Bloomfield	3.50	2.50	5.00	4.50	4.00	11.50	3.50	7.00	6.00	2.50	3.50	7.00	60.50
Brattleboro	5.50	4.00	3.00	4.00	4.50	4.50	1.00	3.50	8.00	3.00	4.50	7.00	52.50
Brentwood	2.50	9.50	2.50	7.00	3.00	7.00	7.50	3.50	3.00	4.00	2.50	4.00	56.00
Brewer	9.50	16.00	4.50	4.50	8.50	5.50	3.50	4.00	2.50	4.50	7.50	10.00	80.50
Bristol	3.50	2.00	4.50	12.50	6.50	3.00	3.50	6.50	8.50	4.00	1.00	4.50	60.00
Cambridge	5.50	4.00	5.00	16.00	5.00	6.00	1.50	7.00	4.50	3.00	3.50	8.50	69.50
Catskill	2.50	5.00	8.50	6.50	3.00	6.00	0.50	6.00	13.50	4.00	3.50	6.50	65.50
Cold Spring Hills	0.50	1.50	7.50	5.00	8.50	5.00	3.00	4.00	6.50	2.50	2.00	3.00	49.00
Colony	6.00	4.00	9.00	2.00	6.50	7.00	6.00	1.00	4.00	5.00	6.50	5.50	62.50
Country	7.00	8.50	3.00	7.00	3.50	6.00	4.00	6.50	9.00	5.00	5.50	10.50	75.50
Dover	2.00	0.50	9.50	5.00	2.50	4.00	2.00	1.00	4.50	6.00	1.50	3.50	42.00
Eastside	4.00	6.00	5.00	7.50	8.00	5.00	2.50	2.50	7.50	3.50	4.00	3.00	58.50
Eliot	0.50	5.00	9.00	4.50	2.00	2.00	2.50	2.50	6.50	1.50	4.50	2.50	43.00
Glen Falls	7.50	2.50	4.50	4.50	6.50	7.50	8.50	2.50	7.50	3.50	1.00	6.00	62.00
Hudson	1.00	7.00	12.50	2.50	6.00	1.50	4.00	0.50	12.00	4.50	2.50	5.50	59.50
Huntington	3.00	1.00	4.50	3.50	3.50	3.50	4.50	0.50	4.50	2.50	2.50	1.00	34.50
Kennebunk	1.00	6.50	6.50	2.00	2.00	7.50	3.00	0.50	5.50	2.50	12.00	0.00	49.00
Ludlowe	6.00	6.00	6.00	3.50	3.50	0.50	3.00	3.00	6.50	5.50	7.00	5.00	55.50
Maple View	4.50	5.50	9.50	3.00	6.00	7.50	6.50	5.50	2.00	9.00	3.50	5.00	67.50
Marlborough	0.50	1.00	3.00	5.50	2.00	2.50	3.50	0.50	3.00	4.00	1.00	2.00	28.50
Maywood	6.00	3.00	5.50	4.50	3.50	3.00	2.50	3.50	5.50	3.50	0.00	5.00	45.50
Milford	2.50	2.50	3.00	0.50	4.00	7.00	4.00	1.00	2.00	2.50	1.00	7.00	37.00
Newton Wellsley	4.50	4.50	3.00	4.00	3.00	7.50	2.50	0.00	2.00	3.00	0.00	1.50	35.50
Norway	5.50	2.00	2.50	2.00	3.50	5.50	5.00	3.50	1.50	5.00	5.50	4.50	46.00
Poughkeepsie	8.50	11.00	3.50	4.00	3.50	7.00	5.50	4.00	14.00	9.00	2.50	9.00	81.50
Regency	1.00	3.50	5.50	1.50	3.50	5.50	4.50	1.50	1.50	2.50	1.00	2.50	34.00
Reservoir	3.00	3.00	6.00	0.50	1.00	3.50	9.00	3.00	3.50	3.50	1.00	5.50	42.50
Riverside	3.00	6.50	4.50	1.50	5.50	2.00	5.50	4.00	4.00	4.50	7.00	2.00	50.00
Ross	7.00	5.50	3.50	5.50	6.00	5.00	6.50	6.50	4.00	2.50	4.50	2.00	58.50
Rutland	1.00	4.00	5.50	0.50	3.00	2.50	2.00	0.50	2.50	1.50	1.00	1.50	25.50
Sachem	4.50	2.50	5.00	4.00	2.50	7.00	2.50	2.50	2.00	3.00	5.50	2.50	43.50
Sands Point	0.50	3.00	4.00	0.50	6.50	7.00	6.50	0.50	2.50	2.50	2.50	2.50	38.50
Utica	2.00	4.50	3.50	4.50	4.50	6.00	3.00	0.50	6.00	6.50	2.50	4.00	47.50
Village Crest	0.50	3.00	4.50	3.50	4.50	7.00	9.50	3.00	2.50	5.00	4.00	0.50	47.50
Water's Edge	1.50	2.50	2.50	4.00	2.00	3.50	2.50	1.50	2.00	3.50	8.50	4.50	38.50
Westgate	1.00	2.00	3.50	7.50	4.50	3.00	3.50	0.00	1.00	0.00	2.00	4.50	32.50
Winship	5.50	4.50	9.50	4.00	4.00	3.00	4.00	1.00	3.50	4.00	1.50	11.00	55.50
Vacation	48.00	0.00	0.00	24.00	0.00	0.00	24.00	48.00	0.00	24.00	40.00	0.00	208.00
Sick	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Personal	0.00	0.00	0.00	8.00	8.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	16.00
Holiday	16.00	0.00	0.00	0.00	0.00	0.00	8.00	8.00	0.00	0.00	0.00	0.00	32.00
Total	205.50	179.50	211.50	202.00	181.00	200.00	188.50	167.00	195.50	176.50	180.50	181.50	2269.00

**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	
New Milford Crossings LLC DBA Village Crest Center for Health and				8771	9/30/2015			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Patricia Page (10/1/14-3/20/15)	55,396			same as employees	Management & supervision of healthcare facility	943	a2			
Donna Orefice (3/21/15-6/19/15)	30,462			same as employees	Management & supervision of healthcare facility	368	a2			
Richard A. Dimeola (6/20/15-9/30/15)	45,291			same as employees	Management & supervision of healthcare facility	769	a2			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
New Milford Crossings LLC DBA Village Crest Ce	8771	9/30/2015	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	6,385	Disallowed				
3. Pharmacist	9,936	24				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	349,847	8,439				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	46,140	221				
b. Utilization Review (Title 18 and 19 only) monthly meeting	100	1				
c. Resident Care**	791	Disallowed				
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	49,851	908				
b. Other						
10. Occupational Therapist						
a. Resident Care	272,471	6,185				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	39,879	432				
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	13,734					
B-13 Total Fees Paid in Lieu of Salaries	789,134	16,210				

* 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		License No.	Report for Year Ended		Page	of
New Milford Crossings LLC DBA Village Crest Center		8771	9/30/2015		14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Gerident Solutions, PO Box 290539, Wethersfield, CT 06129	Dentist	<input type="radio"/>	<input checked="" type="radio"/>			
Procure LTC of CT, 1492 Highland Ave, Cheshire, CT 06410	Pharmacist , Consulting - Nursing	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
William Cicio, 11 Old Park Lane, New Milford, CT 06776	Consulting, Medical Service	<input type="radio"/>	<input checked="" type="radio"/>			
Preferred Therapy, 850 Silas Deane Highway, Wethersfield, CT 06109	PT, OT, ST, Consulting Therapy & Ancillary	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Dr. John Beck, 50 Bridge St, New Milford, CT 06776	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
Dr. John Mullen, 131 Kent Rd, New Milford, CT 06776	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
New Milford Family Practice, 1 Old Park Lane, New Milford, CT 06776	URC	<input type="radio"/>	<input checked="" type="radio"/>			
Associated Pulmonologists of Western CT, Windsor, CT 06006	Physician Fees	<input type="radio"/>	<input checked="" type="radio"/>			
Associated Northwest Urology, PO Box 1736, Sharon, CT 06069	Physician Fees	<input type="radio"/>	<input checked="" type="radio"/>			
Associated Neurologists, 69 Sand Pit Road, Danbury CT 06810	Physician Fees	<input type="radio"/>	<input checked="" type="radio"/>			
Western CT Medical Group, PO Box 8932, Belfast, ME 04915	Physician Fees	<input type="radio"/>	<input checked="" type="radio"/>			
SDX/Swallowing Diagnostic, PO Box 484, Avon, CT 06001	Speech	<input type="radio"/>	<input checked="" type="radio"/>			
Clinical Resources, 3338 Peachtree Road NE, Suite 102, Atlanta GA 30326	Pool RN	<input type="radio"/>	<input checked="" type="radio"/>			
IV Excellence, 32 Falls Ave, Lakeville, CT 06779	IV Therapist	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input 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
New Milford Crossings LLC DBA Village Crest	8771	9/30/2015		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 266,951	266,951			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 98,460	98,460			
4. Social Security (F.I.C.A.)	\$ 287,010	287,010			
5. Health Insurance	\$ 472,992	472,992			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 10,172	10,172			
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>) See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$				
d. Accounting and Auditing	\$ 25,600	25,600			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 17,835	17,835			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 19,075	19,075			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 27,610	27,610			
2. Cellular Phones	\$ 1,284	1,284			
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$				
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (<i>Specify</i>) See Attached Schedule	\$ 159	159			
3. Resident Day User Fee	\$ 518,272	518,272			
Subtotal	\$ 1,745,420	1,745,420			

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended		Page	of
New Milford Crossings LLC DBA Village Crest Cent	8771	9/30/2015		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:					
	1,745,420	1,745,420			
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 4,123	4,123			
3. Gifts to Staff and Residents	\$ 7,171	7,171			
4. Employee Travel	\$ 2,704	2,704			
5. Education Expenses Related to Seminars and Conventions	\$ (197)	(197)			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 618	618			
7. Other (<i>Specify</i>)	\$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 5,327	5,327			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)***	\$ 19,916	19,916			
See Attached Schedule					
4. Fund-Raising***	\$				
5. Medical Records	\$ (106)	(106)			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 3,519	3,519			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>)	\$ 6,783	6,783			
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 280	280			
9. Subscriptions	\$ 60	60			
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>)	\$				
12. Administrative Management Services**	\$ 345,388	345,388			
13. Other (<i>Specify</i>)	\$ 111,723	111,723			
See Attached Schedule					
C-14 Total Administrative & General Expenditures	\$ 2,252,729	2,252,729			

* 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 Promotional- Marketing	\$ 19,916		
Total Other Advertising	\$ 19,916	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Senior Care Resources of Western CT	\$ 300		
CAHCF	\$ 6,483		
Total Dues	\$ 6,783	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Consulting Fees- Fiscal Operations	\$ 2,475		
Purchased Services- Fiscal Operations	\$ 44,560		
Purchased Services- Admin Staff	\$ 30,600		
Licenses and Permits- Administration	\$ 881		
Background Check- Administration and Security	\$ 7,185		
Penalties- Administration- Disallowed	\$ 14		
Bank Charges- Administration- Disallowed	\$ 19,011		
Crime Insurance- Administration - Disallowed	\$ 1,081		
Miscellaneous Expenses- Disallowed	\$ 2,122		
IT Services- Fiscal Operations	\$ 3,794		
Total Other Administrative and General	\$ 111,723	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility New Milford Crossings LLC DBA Village	License No. 8771	Report for Year Ended 9/30/2015	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 #
National Healthcare	345,388	See Attached	page 16, line M12

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

NHCA Manage

Report Date :10/1/2014 - 09/30/2015

	120 Bloomfield	132 Bristol	160 Cambridge	144 Ludlowe	120 Maple View Manor	120 Marlborough	120 Milford	95 New Milford	130 Regency	345 Riverside	150 Water's Edge
Intercompany adjustments (Troy)	(2,575.61)	(2,832.59)	(3,433.76)	(3,090.04)	(2,575.61)	(2,575.61)	(2,575.61)	(2,039.27)	(2,790.15)	(7,405.04)	(3,219.22)
310000-0000-00-0000-0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
400000-0000-00-0000-0	282,655.95	310,874.90	376,948.26	339,185.53	282,655.95	282,655.95	282,655.95	225,193.75	306,200.82	812,641.54	353,304.40
400010-0000-00-0000-0	1,567.09	1,722.79	2,088.64	1,880.49	1,567.09	1,567.09	1,567.09	1,241.08	1,697.60	4,505.76	1,958.10
401000-0000-04-0000-0	18,621.21	20,480.28	24,626.55	22,345.41	18,621.21	18,621.21	18,621.21	14,742.89	20,172.35	53,536.57	23,275.64
401100-0000-04-0000-0	454.22	499.51	605.53	545.03	454.22	454.22	454.22	359.66	462.04	1,305.89	567.74
401101-0000-00-0000-0	(3.74)	(4.11)	(4.99)	(4.49)	(3.74)	(3.74)	(3.74)	(2.96)	(4.05)	(10.75)	(4.68)
401200-0000-04-0000-0	1,653.60	1,818.56	2,204.44	1,984.27	1,653.60	1,653.60	1,653.60	1,309.24	1,791.30	4,754.08	2,066.78
401202-0000-00-0000-0	(102.62)	(112.86)	(136.81)	(123.15)	(102.62)	(102.62)	(102.62)	(81.25)	(111.17)	(295.05)	(128.27)
401250-0000-00-0000-0	518.54	570.35	691.33	622.33	518.54	518.54	518.54	410.56	561.75	1,490.90	648.13
401300-0000-04-0000-0	22,866.50	25,147.97	30,485.17	27,439.83	22,866.50	22,866.50	22,866.50	18,104.85	24,771.16	65,742.55	28,580.53
401400-0000-04-0000-0	20.84	22.53	27.79	25.01	20.84	20.84	20.84	16.50	22.59	59.94	26.05
401600-0000-04-0000-0	502.39	552.47	669.75	602.81	502.39	502.39	502.39	397.73	544.21	1,444.30	627.88
401700-0000-04-0000-0	4,667.41	5,133.07	6,222.49	5,600.86	4,667.41	4,667.41	4,667.41	3,695.46	5,056.17	13,419.02	5,833.72
401800-0000-04-0000-0	682.30	750.45	909.66	818.76	682.30	682.30	682.30	540.18	739.16	1,961.70	852.91
402000-0000-04-0000-0	1,473.35	1,620.36	1,964.25	1,768.02	1,473.35	1,473.35	1,473.35	1,166.53	1,596.08	4,235.95	1,841.54
410000-0000-04-0000-0	3,165.44	3,415.57	4,140.54	3,726.84	3,165.44	3,165.44	3,165.44	2,499.03	3,364.44	8,929.00	3,881.87
410000-0000-09-0000-0	15.27	16.78	20.36	18.33	15.27	15.27	15.27	12.09	16.54	42.90	19.09
410000-0000-09-0000-0	33.37	36.69	44.48	40.04	33.37	33.37	33.37	26.44	36.15	95.94	41.70
410000-0000-12-0000-0	2.53	2.79	3.38	3.04	2.53	2.53	2.53	2.01	2.74	7.28	3.17
411000-0000-04-0000-0	19.64	21.61	26.19	23.57	19.64	19.64	19.64	15.55	21.28	56.46	24.55
431000-0000-03-0000-0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
431000-0000-04-0000-0	7,030.70	7,732.13	9,373.07	8,436.78	7,030.70	7,030.70	7,030.70	5,566.63	7,616.30	20,213.47	8,787.48
432000-0000-03-0000-0	2,283.74	2,511.85	3,044.88	2,740.45	2,283.74	2,283.74	2,283.74	1,807.96	2,473.99	6,565.68	2,854.65
433000-0000-03-0000-0	1,771.23	1,947.98	2,361.37	2,125.50	1,771.23	1,771.23	1,771.23	1,402.38	1,918.79	5,092.41	2,213.88
433100-0000-03-0000-0	(611.80)	(672.84)	(815.64)	(734.16)	(611.80)	(611.80)	(611.80)	(484.40)	(662.76)	(1,758.96)	(764.68)
440000-0000-03-0000-0	9,082.05	9,982.05	11,009.45	9,909.64	8,257.92	8,257.92	8,257.92	6,538.34	8,946.10	23,742.37	10,321.68
440000-0000-08-0000-0	688.71	757.44	918.16	826.58	688.71	688.71	688.71	545.29	746.15	1,980.08	860.81
440000-0000-09-0000-0	900.89	990.69	1,200.92	1,080.87	900.89	900.89	900.89	713.22	975.72	2,589.66	1,125.86
440000-0000-12-0000-0	53.36	58.71	71.17	64.05	53.36	53.36	53.36	42.29	57.83	153.47	66.73
440001-0000-08-0000-0	366.53	403.10	488.63	439.78	366.53	366.53	366.53	290.28	397.06	1,053.73	458.14
441000-0000-03-0000-0	5,676.21	6,242.55	7,567.30	6,811.14	5,676.21	5,676.21	5,676.21	4,494.20	6,148.82	16,319.02	7,094.38
442000-0000-08-0000-0	20.00	21.95	26.65	23.98	20.00	20.00	20.00	15.81	21.62	57.43	24.95
452000-0000-25-0000-0	2,706.81	2,976.72	3,688.72	3,248.36	2,706.81	2,706.81	2,706.81	2,143.04	2,932.26	7,782.25	3,383.22
452100-0000-25-0000-0	(1,194.52)	(1,313.70)	(1,592.51)	(1,433.42)	(1,194.52)	(1,194.52)	(1,194.52)	(945.77)	(1,294.02)	(3,434.31)	(1,493.01)
461000-0000-03-0000-0	2,712.85	2,983.31	3,616.64	3,255.35	2,712.85	2,712.85	2,712.85	2,147.76	2,938.63	7,799.37	3,390.65
461100-0000-03-0000-0	2,006.26	2,206.37	2,674.65	2,407.48	2,006.26	2,006.26	2,006.26	1,588.40	2,173.30	5,767.96	2,507.54
462000-0000-25-0000-0	1,529.87	1,682.44	2,039.55	1,835.81	1,529.87	1,529.87	1,529.87	1,211.25	1,657.25	4,398.44	1,912.13
463000-0000-25-0000-0	443.34	487.58	591.08	523.03	443.34	443.34	443.34	351.02	480.27	1,274.68	554.15
466000-0000-25-0000-0	72.43	79.68	96.60	86.95	72.43	72.43	72.43	57.36	78.50	208.30	90.55
471000-0000-25-0000-0	6,469.09	7,114.48	8,624.40	7,762.81	6,469.09	6,469.09	6,469.09	5,121.91	7,007.84	18,598.85	8,085.55
472000-0000-25-0000-0	516.53	567.96	688.68	619.75	516.53	516.53	516.53	408.91	559.46	1,484.89	645.51
472000-0000-04-0000-0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
473000-0000-25-0000-0	3,426.41	3,788.25	4,568.02	4,111.67	3,426.41	3,426.41	3,426.41	2,712.89	3,711.81	9,851.10	4,282.62
484000-0000-04-0000-0	1,327.68	1,460.13	1,770.03	1,593.23	1,327.68	1,327.68	1,327.68	1,051.22	1,438.25	3,817.12	1,659.43
484100-0000-04-0000-0	13.35	14.69	17.82	16.16	13.35	13.35	13.35	10.59	14.51	38.39	16.71
486000-0000-04-0000-0	7,709.31	8,478.48	10,277.90	9,251.17	7,709.31	7,709.31	7,709.31	6,103.96	8,351.46	22,164.73	9,635.76
491000-0000-03-0000-0	257.10	282.74	342.75	308.54	257.10	257.10	257.10	203.56	278.48	739.13	321.30
500000-0000-03-0000-0	21.32	23.43	28.41	25.57	21.32	21.32	21.32	16.88	23.08	61.27	26.63
501000-0000-03-0000-0	8,395.23	9,232.87	11,192.42	10,074.37	8,395.23	8,395.23	8,395.23	6,647.11	9,094.54	24,136.88	10,493.18
501100-0000-03-0000-0	2,515.58	2,757.65	3,364.56	3,028.53	2,515.58	2,515.58	2,515.58	2,000.00	2,657.89	7,000.00	3,000.00
503000-0000-03-0000-0	403.92	470.31	570.07	513.28	403.92	403.92	403.92	338.59	463.27	1,229.67	534.49
503500-0000-03-0000-0	3.16	33.97	162.47	146.25	3.16	3.16	3.16	96.41	131.87	350.19	152.24
503600-0000-03-0000-0	931.40	1,024.35	1,241.72	1,117.67	931.40	931.40	931.40	737.43	1,008.96	2,677.79	1,164.16
504000-0000-03-0000-0	984.22	1,082.49	1,312.19	1,181.11	984.22	984.22	984.22	779.28	1,066.23	2,825.69	1,230.12
509000-0000-03-0000-0	2,053.89	2,258.79	2,738.16	2,464.68	2,053.89	2,053.89	2,053.89	1,626.30	2,224.99	5,905.05	2,567.16
510000-0000-03-0000-0	2,748.78	3,022.96	3,664.56	3,298.53	2,748.78	2,748.78	2,748.78	2,176.33	2,977.70	7,902.80	3,435.67
511000-0000-03-0000-0	963.25	1,059.28	1,284.11	1,155.92	963.25	963.25	963.25	762.68	1,043.51	2,769.34	1,203.91
512000-0000-03-0000-0	790.75	869.69	1,054.24	948.94	790.75	790.75	790.75	626.14	856.65	2,273.52	988.38
513000-0000-03-0000-0	23.14	25.48	30.93	27.80	23.14	23.14	23.14	18.37	25.12	66.63	28.94
517000-0000-03-0000-0	391.28	430.37	521.69	469.60	391.28	391.28	391.28	309.82	423.89	1,125.10	489.10
520000-0000-03-0000-0	38.53	42.39	51.40	46.24	38.53	38.53	38.53	30.50	41.81	110.77	48.10
520100-0000-03-0000-0	2,966.65	2,965.51	3,595.01	3,235.78	2,966.65	2,966.65	2,966.65	2,134.84	2,921.04	7,752.31	3,369.97
521000-0000-03-0000-0	4,708.93	5,179.26	6,278.29	5,650.74	4,708.93	4,708.93	4,708.93	3,728.03	5,101.27	13,538.39	5,885.96
522000-0000-03-0000-0	4,686.54	5,154.73	6,248.54	5,623.81	4,686.54	4,686.54	4,686.54	3,710.28	5,076.90	13,473.77	5,858.17
540000-0000-31-0000-0	54.63	60.08	72.83	65.55	54.63	54.63	54.63	43.25	59.18	157.05	68.28
541000-0000-03-0000-0	136.48	150.07	181.96	163.77	136.48	136.48	136.48	108.05	147.83	392.41	170.59
541200-0000-31-0000-0	594.10	653.24	792.13	712.97	594.10	594.10	594.10	453.12	643.67	1,788.20	745.20
541001-0000-03-0000-0	5.46	6.01	7.28	6.56	5.46	5.46	5.46	4.33	5.92	15.71	6.83
542000-0000-31-0000-0	199.40	219.30	265.85	239.31	199.40	199.40	199.40				

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

Name of Facility New Milford Crossings LLC DBA Village Crest Center	License No. 8771	Report for Year Ended 9/30/2015	Page 18	of 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 214,474	214,474		
2. Non-Food Supplies	\$ 21,993	21,993		
3. Other (Specify) _____	\$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 16,130	16,130		
c. Management Services**	\$			
d. Other (Specify) _____	\$			
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 252,597	252,597		
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*				
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No				
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> 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? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.				
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> 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? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.				
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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
New Milford Crossings LLC DBA Village Crest Center		8771	9/30/2015	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. \$	16,299	16,299	
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***		Lbs.			
		Amt. \$			
3. Personal clothing of residents washed, ironed, and/or processed.***		Lbs.			
		Amt. \$			
4. Repair and/or purchase of linens.***		Lbs.			
		Amt. \$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	5,561	5,561	
c. Management Services**		\$			
d. Other (Specify) Supplies \$5,444; Diapers \$42,811		\$	48,255	48,255	
3E. Total Laundry Expenditures (3a + b + c + d)		\$	70,115	70,115	
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
H. Did you receive revenue from employees?		<input type="radio"/> Yes	<input checked="" type="radio"/> 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?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K. Did you receive revenue 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)			

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

All allocations should add to total recorded in 3E.

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

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

**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	
New Milford Crossings LLC DBA Village Cres	8771	9/30/2015	20	37	
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care					
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	29,290	29,290		
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. \$				
c. Management Services*	\$				
d. Other (<i>Specify</i>)	\$				
4E. Total Housekeeping Expenditures (4a + b + c + d)	\$	29,290	29,290		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	216,530	216,530		
b. Medicine Cabinet Drugs	\$	13,282	13,282		
c. Medical and Therapeutic Supplies	\$	104,235	104,235		
d. Ambulance/Limousine***	\$	628	628		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	5,848	5,848		
f. X-rays and Related Radiological Procedures***	\$	17,394	17,394		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	23,289	23,289		
i. Recreation	\$	14,371	14,371		
j. Other (Specify)**** See Attached Schedule	\$	45,143	45,143		
5K. Total Resident Care Expenditures (5a - 5j)	\$	440,720	440,720		

* 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)
Purchased Services (Nursing Equipment Testing, Ambulance Charges)	\$ 2,505		
Equipment Rental- Nursing	\$ 6,355		
Equipment Rental - Rehabilitation, Therapy & Ancillary	\$ 15,326		
IV Therapy - Rehabilitation, Therapy & Ancillary	\$ 2,967		
Flu Vaccine- Medical Services	\$ 17,990		
Total Other Resident Care	\$ 45,143	\$ -	\$ -

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

Name of Facility New Milford Crossings LLC DBA Village Crest Center for Health and Reha			License No. 8771		Report for Year Ended 9/30/2015				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	(Specify)	Pg	Line
ADM Environmental Group	1370 Coney Island Ave, Brooklyn, NY 11230	<input type="radio"/>	<input checked="" type="radio"/>	Trash Removal		16,412			22	6f
ADP	PO Box 842875, Boston, MA 02284	<input type="radio"/>	<input checked="" type="radio"/>	PR Processing		12,254			16	m13
Baystate Elevator Co.	PO Box 5, Dalton, MA 01227	<input type="radio"/>	<input checked="" type="radio"/>	Elevator Maintenance		10,753			22	6a
MJ Daly	110 Mattatuck HTS, Waterbury CT 06705	<input type="radio"/>	<input checked="" type="radio"/>	HVAC		10,094			22	6a
Proline	PO Box 150473, Hartford, CT 06015	<input type="radio"/>	<input checked="" type="radio"/>	Dietary Services		12,450			18	2b
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input 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	License No.	Report for Year Ended			Page	of
New Milford Crossings LLC DBA Village Cre	8771	9/30/2015			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 45,042	45,042				
b. Heat	\$ 21,382	21,382				
c. Light & Power	\$ 158,061	158,061				
d. Water	\$ 33,999	33,999				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 24,040	24,040				
f. Other (<i>itemize</i>)	\$ 34,627	34,627				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 317,151	317,151				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 21,451	21,451				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 21,451	21,451				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$ 3,812	3,812				
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 20,386	20,386				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 24,198	24,198				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 308,165	308,165				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 59,759	59,759				
c. Personal property taxes	\$ 6,128	6,128				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 419,701	419,701				

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

New Milford Crossings LLC DBA Village Crest Center for Health and Rehabilitation
9/30/2015

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

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

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/31/2014	Computer Optiplex 30	\$ 896	3	\$ 299
10/31/2014	2 - 4 Draw Chest	\$ 933	10	\$ 93
11/30/2014	1 Toshiba & 1 Vizio TV	\$ 443	5	\$ 81
11/30/2014	Sales Tax on Asset #1	\$ 92	5	\$ 17
4/30/2015	Signa APM w LAL - m	\$ 1,313	5	\$ 131
5/31/2015	Sharp 32" TV Samsung	\$ 610	5	\$ 51
6/30/2015	Control Board for Dryer	\$ 755	10	\$ 25
6/30/2015	Mattress DYN0 APM	\$ 650	5	\$ 43
7/31/2015	Fujitsu Scanner	\$ 914	5	\$ 46
7/31/2015	Dell Optiplex 3020	\$ 809	3	\$ 67
7/31/2015	mattress-Dyno APM	\$ 692	5	\$ 35
8/31/2015	Desktop Computer	\$ 869	3	\$ 48
9/30/2015	Signa APM w LAL-m	\$ 1,165	5	\$ 19
9/30/2015	Vacuum Pump	\$ 1,169	10	\$ 10
Total additions for Movable Equipment		\$ 11,310		\$ 965
Deletions:				
9/30/2015	7 Computers	\$ 6,852	5	\$ 6,852
9/30/2015	Security package	\$ 3,877	5	\$ 3,877
9/30/2015	Equipment @ Closing	\$ 198,000	5	\$ 198,000
9/30/2015	Door Protection Sys	\$ 2,968	5	\$ 2,968
9/30/2015	Printer	\$ 609	5	\$ 609
9/30/2015	Time & Attendance System	\$ 21,850	5	\$ 21,850
9/30/2015	3 Computers	\$ 3,056	5	\$ 3,056
9/30/2015	Heater Base	\$ 896	5	\$ 896
9/30/2015	Patient Room Furniture	\$ 2,777	5	\$ 2,777
9/30/2015	Low Air Loss System	\$ 3,705	5	\$ 3,705
9/30/2015	Alt Pressure w/ LAL	\$ 2,709	5	\$ 2,709
9/30/2015	Alt Pressure w/ LAL	\$ 2,709	5	\$ 2,709
9/30/2015	Alt Pressure w/ LAL	\$ 2,709	5	\$ 2,709
9/30/2015	Alt Pressure w/ LAL	\$ 2,709	5	\$ 2,709
9/30/2015	Alt Pressure w/ LAL	\$ 2,709	5	\$ 2,709
9/30/2015	Bed Frm & Mtrs	\$ 4,426	5	\$ 4,426
9/30/2015	Premium Heat Pump	\$ 7,160	5	\$ 7,160
9/30/2015	Hon Vertical File Cabinet	\$ 848	5	\$ 848
9/30/2015	Smart-Therm Heater	\$ 895	5	\$ 895
9/30/2015	Food Processor	\$ 624	5	\$ 624
9/30/2015	Relief Alternating Pressure	\$ 1,426	5	\$ 1,426
9/30/2015	Low Air Loss System	\$ 3,705	5	\$ 3,705
9/30/2015	31 Bed Frames	\$ 1,314	5	\$ 1,314
9/30/2015	Dyno Relief Alternating Pressu	\$ 1,219	5	\$ 1,219
9/30/2015	Culligan Water System	\$ 10,813	5	\$ 10,813
9/30/2015	HP 4014 Printer	\$ 976	5	\$ 976
9/30/2015	Hitachi CPX2010 Projector	\$ 696	5	\$ 696
9/30/2015	Alt Pressure w/ LAL	\$ 2,703	5	\$ 2,703
9/30/2015	Alt Pressure with LAL	\$ 2,703	5	\$ 2,703
9/30/2015	Dell Latitude E5500	\$ 1,188	5	\$ 1,188
9/30/2015	Relief Max Mattress	\$ 1,219	5	\$ 1,219
9/30/2015	Time and Attendance System	\$ 11,250	5	\$ 11,250
9/30/2015	Altrnting Pressure w/ LAL	\$ 2,709	5	\$ 2,709
9/30/2015	Altrnting Pressure w/ LAL	\$ 2,709	5	\$ 2,709
9/30/2015	Altrnting Pressure w/ LAL	\$ 2,709	5	\$ 2,709
9/30/2015	Altrnting Pressure w/ LAL	\$ 2,709	5	\$ 2,709
9/30/2015	Altrnting Pressure w/ LAL	\$ 2,709	5	\$ 2,709
9/30/2015	Altrnting Pressure w/ LAL	\$ 2,709	5	\$ 2,709
9/30/2015	Altrnting Pressure w/ LAL	\$ 2,709	5	\$ 2,709
9/30/2015	Altrnting Pressure w/ LAL	\$ 2,709	5	\$ 2,709
9/30/2015	Low Air Loss System	\$ 4,236	5	\$ 4,236
	Plug to agree to GL	\$ 651		\$ (1)
Total deletions for Movable Equipment		\$ 337,859		\$ 337,207

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
2/28/2015	Carpet	\$ 1,795	5	\$ 239
5/31/2015	Wiring of Dishwasher	\$ 2,188	20	\$ 46
1/31/2015	Generator Tank Replacement	\$ 65,336	20	\$ 2,450
7/31/2015	Parking Lot Fixtures	\$ 1,880	10	\$ 47
9/30/2015	Walk in Cooler/Freezer	\$ 72,269	15	\$ 401
Total additions for Leasehold Improvement		\$ 143,468		\$ 3,183 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility

Amortization Schedule*

Name of Facility			License No.		Report for Year Ended			Page	of
New Milford Crossings LLC DBA Village Crest Center for H			8771		9/30/2015			24	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							
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				195,223	59,024	SL		17,203	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				143,468		SL		3,183	
C-4. Subtotal									20,386
D. Total Amortization									20,386

* 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 New Milford Crossings LLC DBA Vil	License No. 8771	Report for Year Ended 9/30/2015	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input 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		August 1968			
2. Date Structure Completed		June 1971			
3. If NOT Original Owner, Date of Purchase		02/01/08			
4. Date of Initial Licensure		June 1971			
5. Total Licensed Bed Capacity		95			
6. Square Footage		44,020			
7. Acquisition Cost					
a. Land		59,000			
b. Building		533,000			
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)		Fixed			
b. Date Mortgage Obtained		02/28/11			
c. Interest Rate for the Cost Year		5.81%			
d. Term of Mortgage (number of years)		5			
e. Amount of Principal Borrowed		1,325,000			
f. Principal balance outstanding as of 9/30/15		1,132,935			
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.

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

Name of Facility		License No.	Report for Year Ended		Page	of
New Milford Crossings LLC DBA Vi		8771	9/30/2015		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$ 37,869	37,869		
Name of Lender		Rate				
M&T Bank						
Address of Lender						
303 S. Broadway, Tarrytown, NY, 10591						
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)			\$ 37,869	37,869		

(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
New Milford Crossings LLC DBA		8771		9/30/2015		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				37,869	37,869		
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)				\$	1,879	1,879	
Property interest \$328; Other Admin Interest \$1,551							
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	39,748	39,748	
14. Insurance							
a. Insurance on Property (buildings only)				\$	10,925	10,925	
b. Insurance on Automobiles				\$	2,456	2,456	
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$	11,440	11,440	
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$	42,400	42,400	
General Liability							
14d. Total Insurance Expenditures (14a + b + c)				\$	67,221	67,221	
15. Total All Expenditures (A-13 thru C-14)				\$	8,598,016	8,598,016	

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
New Milford Crossings LLC DBA Village Crest Center for Hea				8771	9/30/2015	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.	10	12m	Salaries not related to Resident Care	\$ 13,318	13,318		
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 9,231	9,231		
Page 13 - Professional Fees							
5.	13	8e / 8	Resident Care Physicians **	\$ 791	791		
6.	13	10a	Occupational Therapy	\$ 272,471	272,471		
7.			Other - See attached Schedule	\$ 31,142	31,142		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.	15	1e	Accounting & Legal	\$ 8,834	8,834		
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$ 564	564		
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	m3	Unallowable Advertising *	\$ 19,916	19,916		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.	15	1d	Unallowable Management Fees	\$ 148,208	148,208		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 33,538	33,538		
Page 18 - Dietary Expenditures							
24.	18	2A1	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)				\$ 538,013	538,013		

* 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)
10	a2	Severance Pay	\$ 9,231		
Total Other Salaries Adjustment			\$ 9,231	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B2	Dentist	\$ 6,385		
13	B12	IV Therapy	\$ 10,110		
13	8a	Medical Director	\$ 11,023		
13	B12	Consulting Fees Rehabilitation, Therapy, and Ancillary	\$ 1,605		
13	B12	Consulting Fees Nursing	\$ 2,019		
Total Other Fees Adjustments			\$ 31,142	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
15	1a	Benefits on Salaries not Related to Resident Care	\$ 3,859		
16	L3	Gifts to Residents and Staff	\$ 7,171		
16	M13	Crime Insurance - Admin	\$ 1,081		
16	M13	Miscellaneous Expenses	\$ 2,122		
16	M13	Penalties - Admin	\$ 14		
16	M13	Bank Charges - Admin	\$ 19,011		
16	M8a	Chamber of Commerce Dues	\$ 280		
Total Other A&G Adjustments			\$ 33,538	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
New Milford Crossings LLC DBA Village Crest Center for H				8771	9/30/2015	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 538,013	538,013		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 216,530	216,530		
28.	20	5d	Ambulance/Limousine	\$ 628	628		
29.	20	5f	X-rays, etc	\$ 17,394	17,394		
30.	20	5h	Laboratory	\$ 23,289	23,289		
31.	20	5c	Medical Supplies	\$ 6,177	6,177		
32.	20	5e2	Oxygen (non emergency)	\$ 5,848	5,848		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 49,541	49,541		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.	22	10c	Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$ 4,929	4,929		
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.	30	IV5	Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$ 6,200	6,200		
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51.	Total Amount of Decrease (Items 1 - 50)			\$ 868,549	868,549		

*** 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.

New Milford Crossings LLC DBA Village Crest Center for Health and Rehabilitation
9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Equipment Rental	\$ 6,355		
20	5j	Equipment Rental - Rehabilitation, Therapy & Ancillary	\$ 15,326		
20	5a2/b/c	Procure LTC Pharmacy of CT (Disallowance of markups)	\$ 1,081		
20	5j	IV Therapy - Rehabilitation, Therapy & Ancillary	\$ 2,967		
20	5j	Flu Vaccine- Medical Services	\$ 17,990		
20	5i	Cable TV Expense - Resident Rooms	\$ 5,822		
Total Other Ancillary Costs			\$ 49,541	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	8d	Organizational Cost Depreciation- Disallowed	\$ 3,812		
22	7d	Depreciation on Mattresses	\$ 494		
22	7d	Depreciation on TV's	\$ 623		
Total Other Property Adjustments			\$ 4,929	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30	IV8	SCA Personal Care - Diapers Rebate	\$ 1,449		
30	IV8	Other Income	\$ 2,903		
30	IV5	Interest Income	\$ 297		
27	12D	Other Interest	\$ 1,551		
Total Other Adjustments			\$ 6,200	\$ -	\$ -

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility		License No.		Report for Year Ended		Page	of
New Milford Crossings LLC DBA Village		8771		9/30/2015		30	37
Item	Total	CCNH	RHNS	(Specify)			
I. Resident Room, Board & Routine Care Revenue							
1. a. Medicaid Residents (<i>CT only</i>)	\$ 7,922,332	7,922,332					
b. Medicaid Room and Board Contractual Allowance **	\$ (3,037,325)	(3,037,325)					
2. a. Medicaid (<i>All other states</i>)	\$						
b. Other States Room and Board Contractual Allowance **	\$						
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 2,145,939	2,145,939					
b. Medicare Room and Board Contractual Allowance **	\$ 807,623	807,623					
4. a. Private-Pay Residents and Other	\$ 1,162,696	1,162,696					
b. Private-Pay Room and Board Contractual Allowance **	\$ (170,490)	(170,490)					
II. Other Resident Revenue							
1. a. Prescription Drugs - Medicare	\$ 140,600	140,600					
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (140,600)	(140,600)					
c. Prescription Drugs - Non-Medicare	\$ 68,313	68,313					
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (68,405)	(68,405)					
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	\$ 550,135	550,135					
b. Physical Therapy - Medicare Contractual Allowance **	\$ (462,272)	(462,272)					
c. Physical Therapy - Non-Medicare	\$ 128,576	128,576					
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (128,576)	(128,576)					
4. a. Speech Therapy - Medicare	\$ 71,289	71,289					
b. Speech Therapy - Medicare Contractual Allowance **	\$ (34,755)	(34,755)					
c. Speech Therapy - Non-Medicare	\$ 13,089	13,089					
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (13,089)	(13,089)					
5. a. Occupational Therapy - Medicare	\$ 449,452	449,452					
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (401,041)	(401,041)					
c. Occupational Therapy - Non-Medicare	\$ 123,290	123,290					
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (123,290)	(123,290)					
6. a. Other (<i>Specify</i>) - Medicare	\$ 1,567	1,567					
b. Other (<i>Specify</i>) - Non-Medicare	\$ 149	149					
III. Total Resident Revenue (Section I. thru Section II.)	\$ 9,005,207	9,005,207					
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 (<i>Specify</i>)	\$ 297	297					
6. Private Duty Nurses' Fees	\$						
7. Barber, Coffee, Beauty and Gift shops	\$						
8. Other (<i>Specify</i>)	\$ 50,272	50,272					
V. Total Other Revenue (1 thru 8)	\$ 50,569	50,569					
VI. Total All Revenue (III +V)	\$ 9,055,776	9,055,776					

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30, Line II6a	Medicare Pt A Contra Other	\$ (25,108)		
30, Line II6a	Medicare Pt A Lab	\$ 14,651		
30, Line II6a	Medicare Pt A X-Ray	\$ 10,457		
30, Line II6a	Medicare Pt B Flu/Pneumonia	\$ 1,666		
30, Line II6b	Mgd Medicare Contra Other	\$ (99)		
Total Other Resident Revenue - Medicare		\$ 1,567	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30, Line II6b	Medicaid Contra Other	\$ (220)		
30, Line II6b	Private X-Ray	\$ 154		
30, Line II6b	Medicaid Lab	\$ 220		
30, Line II6b	Private Contra Other	\$ (98)		
30, Line II6b	Private Lab	\$ 93		
30, Line II6b	Commercial Insurance Contra Other	\$ (9,510)		
30, Line II6b	Commercial Insurance Lab	\$ 5,478		
30, Line II6b	Commercial Insurance X Ray	\$ 4,032		
Total Other Resident Revenue		\$ 149	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30, Line IV8	Interest from M&T Savings Account		\$ 297		
Total Interest Income			\$ 297	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30, Line IV8	Prior Period Other	\$ 24,183		
30, Line IV8	Change in Interest Rate Swap	\$ 11,354		
30, Line IV8	United Healthcare	\$ 10,383		
30, Line IV8	SCA Personal Care - Rebate	\$ 1,449		
30, Line IV8	Other	\$ 2,903		
Total Other Revenue		\$ 50,272	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Crossings LLC DBA Vill	8771	9/30/2015	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	600,447
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,027,926
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	42,216
5. Prepaid Expenses			\$	149,556
a. Insurance (Property; Workers Comp)	43,940			
b. Taxes (Pers Prop, Real Estate, Corp Income)	67,586			
c. Management Assets	32,972			
d. Other	5,058			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	92,204
Patient funds	22,193			
Due from Related Party	70,011			
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,912,349
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 <u>338,691</u>		\$	259,281
	Accum. Depreciation <u>79,410</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>144,994</u>		\$	87,706
	Accum. Depreciation <u>57,288</u>	Net		
7. Motor Vehicles	*Historical Cost <u>15,661</u>		\$	9,788
	Accum. Depreciation <u>5,873</u>	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	302,358
Construction In Progress	302,358			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	659,133

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility New Milford Crossings LLC DBA Villa	License No. 8771	Report for Year Ended 9/30/2015	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$ 2,571,482	
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 (<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>)			\$ 910,475	
Goodwill		884,317		
Security Deposits		26,158		
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ 910,475	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 3,481,957	

* 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		License No.	Report for Year Ended	Page	of
New Milford Crossings LLC DBA Village Cr		8771	9/30/2015	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	365,328
2. Notes Payable (<i>itemize</i>)				\$	

3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	250,520
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	630,818
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	292,470
Accrued Expenses		97,487			
Patient Funds		22,193			
Due to Related Party		45,955			
Accrued User Fee		126,835			
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	1,539,136

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility New Milford Crossings LLC DBA Village	License No. 8771	Report for Year Ended 9/30/2015		Page 34	of 37
Account				Amount	
Total Brought Forward:				1,539,136	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					
Name of Lender	Purpose	Amount	Date Due	\$	
2. Mortgages Payable				\$	
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>)				\$	
		Interest Rate Swap	5,721	5,721	
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 5,721	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 1,544,857	

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

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Crossings LLC DBA Vil	8771	9/30/2015	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<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. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	1,479,340
6. Gain or Loss for Period			\$	457,760
	10/1/2014	thru	9/30/2015	
7. Total Net Worth			\$	1,937,100
C. Total Reserves and Net Worth			\$	1,937,100
D. Total Liabilities, Reserves, and Net Worth			\$	3,481,957

H. Changes in Total Net Worth

Name of Facility New Milford Crossings LLC DBA Villag	License No. 8771	Report for Year Ended 9/30/2015	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2014			\$	1,562,101
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	9,055,776
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	8,598,016
D. Net Income or Deficit			\$	457,760
E. Balance			\$	2,019,861
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
Tax refund	3,239			
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	3,239
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	50,000
Name and Address (<i>No., City, State, Zip</i>)	Title	Amount		
EP Investors		50,000		
2. Other Withdrawings (<i>Specify</i>)			\$	36,000
Purpose	Amount			
Taxes	36,000			
3. Total Deductions			\$	86,000
H. Balance at End of Period			\$	1,937,100
				09/30/15

I. Preparer's/Reviewer's Certification

Name of Facility New Milford Crossings LLC DBA Village	License No. 8771	Report for Year Ended 9/30/2015	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 type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<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 <i>Blum, Shapiro & Company, P.C.</i>		Title		Date Signed <i>2/15/16</i>
Printed Name of Preparer Blum Shapiro & Co				
Address Address 29 South Main Street, West Hartford, CT 06127			Phone Number 860-561-4000	