State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2015

Name of Facility (as licensed) The Kent, LTD		
Address (No. & Street, City, State, Zip Code) 46 Maple Street Kent, CT 06757		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2147-C			07-5391

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	21189		

For Department Use Only

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

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CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
The Kent, LTD	2147-C	9/30/2016	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for The Kent, LTD [facility name], for the cost report period beginning October 1, 2015 and ending September 30, 2016, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

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

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility The Kent, LTD	Period Covered:		From 10/1/2015	To 9/30/2016
Address of Facility 46 Maple Street Kent, CT 06757				
Report Prepared By Apple Health Care, Inc.	Phone Number (860) 678-9755		Date	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
(860) 927-5368	9/30/2016	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
The Kent, LTD	46 Maple Street Kent, CT 06757

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2147-C			07-5391

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

If this facility opened or closed during report year provide:	Date Opened	Date Closed
		1/7/2016

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Linda Urbanski	0001170

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

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

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
The Kent, LTD	46 Maple Street Kent, CT 06757	Connecticut

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

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General Information and Questionnaire
Individual Proprietorship

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ⊙ No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? ⊙ Yes ○ No

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Brian J. Foley	21 Waterville Road Avon, CT	○	⊙		Real Estate Rental	Pg. 22 Line 9	209,677	209,677
Apple Health Care	21 Waterville Road Avon, CT	○	⊙		Management & Accounting Services	Pg. 16 Line m12	90,729	90,729
Healthport Services	21 Waterville Road Avon, CT	○	⊙		Employee Staffing	Pg. 10 Schedule	7,943	7,943
Allstar	21 Waterville Road Avon, CT	⊙	○	7%	Therapy Services	Pg. 13 B5/B9/B10	1,324	1,214
Corporate Employee	21 Waterville Road Avon, CT	○	⊙		Employee Staffing	Pg. 10 Schedule		
Employees @ various Apple Facilities		○	⊙		Employee Staffing	Pg. 10 Schedule	29,824	29,824
Apple Health Care	21 Waterville Road Avon, CT	○	⊙		Pension Plan (401K)	Pg. 15 1a7	1,246	1,246
Aetna	PO Box 88860 Chicago, IL	⊙	○		Group Medical	Pg. 15 1a5	88,140	
Delta Dental	PO Box 23700 Newark, NJ	⊙	○		Group Dental	Pg. 15 1a5	4,393	

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes x No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? x Yes No

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Aetna	PO Box 88860 Chicago, IL	X			Group Life & Disability	Pg. 15 1a6	12,658	
Marsh	PO Box 19636 Newark, NJ	X			Property, Liability, & Umbrella Insura	Pg. 27 14a	34,755	
Bendan Foley	21 Waterville Rd. Avon, CT	X				##		
Ryan Vess	21 Waterville Rd. Avon, CT		X			##		

* Use additional sheets if necessary.
** Provide the percentage amount of revenue received from non-related parties.
Related expense has been disallowed on Pg. 28 Line 23

Kent Shared Employee Report
Reporting Period: From 9/20/2015 to 1/23/2016

Emp Num	LastName	FirstName	HomeFcltyCode	Home Facility
11006061	JACOB	JULIE	11	Wolcott Hall
11006061	JACOB	JULIE	11	Wolcott Hall
11006061	JACOB	JULIE	11	Wolcott Hall
11006061	JACOB	JULIE	11	Wolcott Hall
11006061	JACOB	JULIE	11	Wolcott Hall
11006061	JACOB	JULIE	11	Wolcott Hall
11006061	JACOB	JULIE	11	Wolcott Hall
11006061	JACOB	JULIE	11	Wolcott Hall
11006061	JACOB	JULIE	11	Wolcott Hall
11006061	JACOB	JULIE	11	Wolcott Hall
7970192	NOREIKA	MICHELLE	7	Watertown
7970192	NOREIKA	MICHELLE	7	Watertown
7970192	NOREIKA	MICHELLE	7	Watertown
7970192	NOREIKA	MICHELLE	7	Watertown
7970192	NOREIKA	MICHELLE	7	Watertown
7970192	NOREIKA	MICHELLE	7	Watertown
7970192	NOREIKA	MICHELLE	7	Watertown
7970192	NOREIKA	MICHELLE	7	Watertown
7970192	NOREIKA	MICHELLE	7	Watertown
11006061	JACOB	JULIE	11	Wolcott Hall
11006061	JACOB	JULIE	11	Wolcott Hall
11006061	JACOB	JULIE	11	Wolcott Hall
11006061	JACOB	JULIE	11	Wolcott Hall
11970362	HAZZARD	ADELINE	11	Wolcott Hall
11970362	HAZZARD	ADELINE	11	Wolcott Hall
11970362	HAZZARD	ADELINE	11	Wolcott Hall
11970362	HAZZARD	ADELINE	11	Wolcott Hall
11970362	HAZZARD	ADELINE	11	Wolcott Hall
11970362	HAZZARD	ADELINE	11	Wolcott Hall
11970362	HAZZARD	ADELINE	11	Wolcott Hall
11970362	HAZZARD	ADELINE	11	Wolcott Hall
11970362	HAZZARD	ADELINE	11	Wolcott Hall
11970362	HAZZARD	ADELINE	11	Wolcott Hall
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11970362	HAZZARD	ADELINE	11	Wolcott Hall
11970362	HAZZARD	ADELINE	11	Wolcott Hall

11970362	HAZZARD	ADELINE	11	Wolcott Hall
11970362	HAZZARD	ADELINE	11	Wolcott Hall
29970365	CARRIGAN	GORDON	29	Healthport Srvcs
29970365	CARRIGAN	GORDON	29	Healthport Srvcs
29970365	CARRIGAN	GORDON	29	Healthport Srvcs
29970365	CARRIGAN	GORDON	29	Healthport Srvcs
23050525	CAREY	JEFFREY	23	Kent

WorkedFcltyCode	Worked Facility	GL Code
23	Kent	923-41002
23	Kent	923-41002
23	Kent	923-41002
23	Kent	923-41002
23	Kent	923-41002
23	Kent	923-41002
23	Kent	923-41002
23	Kent	923-41002
23	Kent	923-41002
23	Kent	923-41002
23	Kent	923-41003
23	Kent	923-41003
23	Kent	923-41003
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23	Kent	923-41003
23	Kent	923-41003
23	Kent	923-41004
23	Kent	923-41004
23	Kent	923-41004
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23	Kent	923-41004

23	Kent	923-4100
23	Kent	923-4100
23	Kent	923-4100
23	Kent	923-4100
23	Kent	923-4100
23	Kent	923-4100
2	Rose Haven	902-5000

Report Date

GL Description	PayDate	Hours
Salaries - Clerical - JobTitle = HR Coordinator	10/22/2015	0.00
Salaries - Clerical - JobTitle = HR Coordinator	10/29/2015	0.00
Salaries - Clerical - JobTitle = HR Coordinator	11/5/2015	0.00
Salaries - Clerical - JobTitle = HR Coordinator	11/12/2015	0.00
Salaries - Clerical - JobTitle = HR Coordinator	11/25/2015	0.00
Salaries - Clerical - JobTitle = HR Coordinator	12/10/2015	0.00
Salaries - Clerical - JobTitle = HR Coordinator	12/23/2015	0.00
Salaries - Clerical - JobTitle = HR Coordinator	12/31/2015	0.00
Salaries - Clerical - JobTitle = HR Coordinator	1/7/2016	0.00
Salaries - Clerical - JobTitle = HR Coordinator	1/14/2016	0.00
	Total	**0.00**
Salaries - Accounting - JobTitle = HR / A/P Coordinator	10/22/2015	0.00
Salaries - Accounting - JobTitle = HR / A/P Coordinator	10/29/2015	0.00
Salaries - Accounting - JobTitle = HR / A/P Coordinator	11/5/2015	0.00
Salaries - Accounting - JobTitle = HR / A/P Coordinator	11/12/2015	0.00
Salaries - Accounting - JobTitle = HR / A/P Coordinator	11/19/2015	0.00
Salaries - Accounting - JobTitle = HR / A/P Coordinator	11/25/2015	0.00
Salaries - Accounting - JobTitle = HR / A/P Coordinator	12/10/2015	0.00
Salaries - Accounting - JobTitle = HR / A/P Coordinator	12/17/2015	0.00
Salaries - Accounting - JobTitle = HR / A/P Coordinator	1/21/2016	0.00
Salaries - Accounting - JobTitle = HR / A/P Coordinator	11/19/2015	0.00
Salaries - Accounting - JobTitle = HR / A/P Coordinator	12/3/2015	0.00
Salaries - Accounting - JobTitle = HR / A/P Coordinator	12/17/2015	0.00
Salaries - Accounting - JobTitle = HR / A/P Coordinator	1/21/2016	0.00
	Total	**0.00**
Salaries - Social Services/Admissions - JobTitle = SOCIAL SERVICES - B	10/1/2015	4.50
Salaries - Social Services/Admissions - JobTitle = SOCIAL SERVICES - B	10/8/2015	4.50
Salaries - Social Services/Admissions - JobTitle = SOCIAL SERVICES - B	10/15/2015	3.00
Salaries - Social Services/Admissions - JobTitle = SOCIAL SERVICES - B	10/22/2015	3.00
Salaries - Social Services/Admissions - JobTitle = SOCIAL SERVICES - B	10/29/2015	6.00
Salaries - Social Services/Admissions - JobTitle = SOCIAL SERVICES - B	11/5/2015	3.00
Salaries - Social Services/Admissions - JobTitle = SOCIAL SERVICES - B	11/12/2015	3.00
Salaries - Social Services/Admissions - JobTitle = SOCIAL SERVICES - B	11/19/2015	1.50
Salaries - Social Services/Admissions - JobTitle = SOCIAL SERVICES - B	11/25/2015	3.00
Salaries - Social Services/Admissions - JobTitle = SOCIAL SERVICES - B	12/3/2015	1.50
Salaries - Social Services/Admissions - JobTitle = SOCIAL SERVICES - B	12/10/2015	1.50
Salaries - Social Services/Admissions - JobTitle = SOCIAL SERVICES - B	12/17/2015	1.50
Salaries - Social Services/Admissions - JobTitle = SOCIAL SERVICES - B	12/23/2015	1.50
Salaries - Social Services/Admissions - JobTitle = SOCIAL SERVICES - B	12/31/2015	1.50

Salaries - Social Services/Admissions - JobTitle = SOCIAL SERVICES - B	1/7/2016	1.50
Salaries - Social Services/Admissions - JobTitle = SOCIAL SERVICES - B	1/14/2016	3.00
	Total	**43.50**
Salaries - Maintenance - JobTitle = MAINTENANCE SUPERVISOR	10/22/2015	40.00
Salaries - Maintenance - JobTitle = MAINTENANCE SUPERVISOR	10/29/2015	40.00
Salaries - Maintenance - JobTitle = MAINTENANCE SUPERVISOR	11/5/2015	37.00
Salaries - Maintenance - JobTitle = MAINTENANCE SUPERVISOR	11/12/2015	16.00
	Total	**133.00**
Salaries - Chefs Cooks - JobTitle = Cook Supervisor	10/15/2015	0
	Total	**0**
	Total	**176.50**

#######

Dollars

300.00
150.00
150.00
150.00
150.00
150.00
150.00
150.00
150.00
150.00
1,650.00

150.00
150.00
150.00
150.00
150.00
150.00
150.00
150.00
150.00
150.00
150.00
150.00
1,950.00

112.50
112.50
75.00
75.00
150.00
75.00
75.00
37.50
75.00
37.50
37.50
37.50
37.50
37.50

37.50
75.00
1,087.50

1,000.00
1,000.00
925.00
400.00
3,325.00

(70.00)
(70.00)

7,942.50

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (*See listing page 13*)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

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

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

2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.

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

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

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

N/A

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General Information and Questionnaire
Leases (Excluding Real Property)

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

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

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

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

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
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The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Saslow, Lufkin, & Buggy, LLP	10 Tower Lane Avon, CT 06001
2 Huban & Brazee	35 Wendell Avenue Pittsfield, MA 10202
3	
4	

Services Provided by This Firm (*describe fully*)

1	Preparation of audited financials (dissallow Pg. 28)	$ 1,207
2	Preparation of tax returns	$ 1,136
3		$
4		$
		Charge for Services Provided $ 2,343

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

⊙ Yes ○ No Pg. 15 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Clerk of Superior Court	
2 Pullman & Comley LLC	
3 Summa & Ryan PC	
4	
5	

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	Probate	$ 100
2	Legal advice - Property	$ 677
3	Legal advice - Closing Facility	$ 1,103
4		$
5		$
		Charge for Services Provided $ 1,880

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

⊙ Yes ○ No Pg. 15 1e

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	90	90			90	90			90	90		
B. On last day of THIS report period	90	90			90	90			90	90		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	19	19			19	19						
B. As of midnight of THIS report period												
3. Total Number of Days Care Provided During Period												
A. Medicare	7	7			7	7						
B. Medicaid (Conn.)	603	603			603	603						
C. Medicaid (other states)	31	31			31	31						
D. Private Pay	60	60			60	60						
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	701	701			701	701						
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	701	701			701	701						

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

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

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

Change in Resident Days	CCNH	RHNS	(Specify)
1st change			
2nd change			
3rd change			
4th change			

6. Number of Residents and Rates on September 30 of Cost Year

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents								
Per Diem Rate								
a. One bed rm.		256.47						
b. Two bed rms.	442.49	238.84		350.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	1	1		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	15	15		
D. ***Total Physical Therapy Treatments***	16	16		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	11	11		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. ***Total Speech Therapy Treatments***	11	11		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	9	9		
D. ***Total Occupational Therapy Treatments***	9	9		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
The Kent, LTD	2147-C	9/30/2016	10	37

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	26,500	497				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	8,042	229				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	10,679	534				
c. Dietary Workers	29,171	3,387				
6. Housekeeping Service						
a. Head Housekeeper	19,334	325				
b. Other Housekeeping Workers	12,941	1,494				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	19,062	808				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	4,485	520				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants	19,785	218				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	22,035	453				
b. RN						
1. Direct Care	132,331	5,811				
2. Administrative**	5,569	214				
c. LPN						
1. Direct Care	78,755	5,908				
2. Administrative**						
d. Aides and Attendants	66,267	7,591				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	14,614	483				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	40,281	677				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	509,852	29,150				

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

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CSP-11 Rev. 10/2005

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
The Kent, LTD	2147-C	9/30/2016	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										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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CSP-12 Rev. 10/2005

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
The Kent, LTD	2147-C	9/30/2016	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Linda Urbanski	26,500				Administrator 10/1/15 - 1/7/16	497	A2			
Section IV - Assistant Administrators										

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

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

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

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CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
The Kent, LTD	2147-C	9/30/2016	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	3,583	36				
3. Pharmacist	2,565	25				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	480	4				
b. Other						
6. Social Worker	200	2				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	6,677					
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	577	3				
b. Other						
10. Occupational Therapist						
a. Resident Care	268	2				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	748					
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	15,098	72				

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

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

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

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CSP-14 Rev. 6/95

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
The Kent, LTD	2147-C	9/30/2016	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Douglas Finch MD PO Box 1009 Kent, CT	Medical Director	○	⊙	
Healthdrive 888 Worchester St. Wellesly, MA	Dentist	○	⊙	
West River Pharmacy 41 Northwest Dr. Plainville, CT	Pharmacist	○	⊙	
Deborah Proscher 167 S. Parliman Rd.	Social Worker	○	⊙	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
The Kent, LTD	2147-C	9/30/2016	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	(14,768)	(14,768)		
2. Disability Insurance	$				
3. Unemployment Insurance	$	7,501	7,501		
4. Social Security (F.I.C.A.)	$	41,883	41,883		
5. Health Insurance	$	67,766	67,766		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	12,658	12,658		
7. Pensions (Non-Discriminatory)	$	1,246	1,246		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	312,783	312,783		
d. Accounting and Auditing	$	2,343	2,343		
e. Legal (*Services should be fully described on Page 7)*	$	1,880	1,880		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	906	906		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	6,655	6,655		
2. Cellular Phones	$				
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	15,029	15,029		
Subtotal	$	455,882	455,882		

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

(Carry Subtotals forward to next page)

***** DO NOT Include Holiday Parties / Awards / Gifts to Staff**

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Kent, LTD	2147-C	9/30/2016	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		455,882	455,882		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	14,694	14,694		
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$	1,574	1,574		
4. Employee Travel	$	3,921	3,921		
5. Education Expenses Related to Seminars and Conventions	$	200	200		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$				
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	124	124		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	1,176	1,176		
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	347	347		
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions***	$				
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$	90,729	90,729		
13. Other (*Specify*)	$	12,853	12,853		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	581,499	581,499		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Advertising - Public Relations	$ 124		
Total Other Advertising	$ 124	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 347		
Total Dues	$ 347	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Corporate Fees - Non Reimbursable	$ 8,093		
Licenses & Fees	$ 2,071		
Pre Employment Screening	$ 174		
Point Click Care Fees	$ 198		
Bank Charges	$ -		
Resident Expenses	$ 2,260		
Account Write Off	$ 57		
Total Other Administrative and General	$ 12,853	$ -	$ -

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CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
The Kent, LTD	2147-C	9/30/2016	17 | 37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Apple Health Care, Inc.	90,729	Accounting & Managerial Services	Pg. 16 m12

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

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CSP-18 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page
The Kent, LTD	2147-C	9/30/2016	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	7,842	7,842		
2. Non-Food Supplies	$	1,253	1,253		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	141	141		
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	9,236	9,236		

2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals:	Total no. of meals served per day:*	21	21		

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

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

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CSP-19 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page
The Kent, LTD	2147-C	9/30/2016	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $	658	658		
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)*	$				
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	658	658		

3F.	Laundry Questionnaire			
G.	Is cost of employee laundry included in 3E?	○ Yes	⊙ No	If yes, specify cost.
H.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	○ Yes	⊙ No	If yes, specify cost.
K.	Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
L.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3E.

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

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

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CSP-20 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Kent, LTD	2147-C	9/30/2016	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	1,493	1,493		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	9,816	9,816		
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	11,309	11,309		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from West River Pharmacy		$	3,363	3,363		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	4,859	4,859		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	725	725		
f. X-rays and Related Radiological Procedures***		$	317	317		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	129	129		
i. Recreation		$	7,322	7,322		
j. Other (Specify)**** See Attached Schedule		$	102	102		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	16,818	16,818		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Nursing Station Supplies	$ 27		
Rehab Service Supplies	$ -		
IV Therapy Supplies	$ 75		
Social Service Supplies	$ -		
Total Other Resident Care	$ 102	$ -	$ -

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CSP-21 Rev. 10/2001

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Kent, LTD	2147-C	9/30/2016	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

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

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CSP-22 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
The Kent, LTD	2147-C	9/30/2016	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	34,126	34,126		
b. Heat	$	11,777	11,777		
c. Light & Power	$	26,281	26,281		
d. Water	$	18,998	18,998		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	6,241	6,241		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	97,423	97,423		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	688	688		
d. Movable Equipment	$	7,296	7,296		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	7,984	7,984		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	6,098	6,098		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	6,098	6,098		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	209,677	209,677		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	23,119	23,119		
c. Personal property taxes	$	909	909		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	247,788	247,788		

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

Schedule of Other Repairs and Maintenance

Description	**CCNH**	**RHNS**	**(Specify)**
Refuse Removal	$ 6,241		
Total Other Repairs and Maintenance	$ 6,241	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
The Kent, LTD	2147-C	9/30/2016	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	418,745		418,745	387,818	SL	Various	175	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	19,786						513	
C-4. Subtotal								688

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			Var	Var	743,532		743,532	599,613	SL	Various	6,841	
b. Disposals (attach schedule)					(2,609)		(2,609)		SL		(932)	
c. Acquired during this report period (attach schedule)			Var	Var	8,733		8,733		SL	Various	1,387	
D-3. Subtotal												7,296
E. ***Total Depreciation***												7,984

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Schedule of Land Improvements Acquired during this report period

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

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

Schedule of Building Improvements Acquired during this report period

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

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

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
8/17/2015	Emergency Generator	$ 1,514	20	$ 39	
8/17/2015	Emergency Generator	$ 565	20	$ 15	
8/17/2015	Emergency Generator	$ 17,707	20	459.34	
Total additions for Non-Movable Equipment		$ 19,786		$ 513	*
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:					
6/20/2014	Patient Lift Repairs	$ 3,683	5	$ 798	
8/20/2015	Patient Lift Repairs	$ 5,050	5	$ 589	
Total additions for Movable Equipment		$ 8,733		$ 1,387	*
Deletions:					
7/12/2013	ECG Interpretive 12 Lead	$ (2,609)	7	$ (932)	
Total deletions for Movable Equipment		$ (2,609)		$ (932)	**

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

Schedule of Leasehold Improvements Acquired during this report period

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

***Ties to Page 24, Line C3**
****Ties to Page 24, Line C2**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
The Kent, LTD	2147-C	9/30/2016	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	Var	Var		716,154	558,549	A		6,098	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									6,098
D. ***Total Amortization***									6,098

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Kent, LTD	2147-C	9/30/2016	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	90
6. Square Footage	
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed	See Attached			
f. Principal balance outstanding as of _____				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Connecticut Facilities

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

Out of State Facilities

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

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

Name of Facility	License No.	Report for Year Ended	Page of
The Kent, LTD	2147-C	9/30/2016	26 | 37

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

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
The Kent, LTD	2147-C	9/30/2016	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				
12. C. Movable Equipment 1. Automotive Equipment $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
2. Other (*Specify*) $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
B. Item / Rate / Amount				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $				
12. D. Other Interest Expense (*Specify*) $ Interest on Value Term Note	573	573		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	573	573		
14. Insurance				
a. Insurance on Property (buildings only) $	34,755	34,755		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $				
2. Fire and Extended Coverage $				
3. Other (*Specify*) $				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	34,755	34,755		
15. ***Total All Expenditures (A-13 thru C-14)*** $	1,525,009	1,525,009		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
The Kent, LTD	2147-C	9/30/2016	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	B10a	Occupational Therapy $	268	268		
7.			Other - See attached Schedule $	6,677	6,677		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	312,783	312,783		
10.	15	1d/e	Accounting & Legal $	1,307	1,307		
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.	16	m2/3	Unallowable Advertising * $	124	124		
19.			Income Tax / Corporate Business Tax $				
20.	16	m10	Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	16,042	16,042		
Page 18 - Dietary Expenditures							
24.	30	IV1	Meals to employees, guests and others who are not residents $				
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	337,201	337,201		

* 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	12m	Social Serivce/Marketing			
Total Other Salaries Adjustment			$ -	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B8	Medical Director	$ 6,677		
Total Other Fees Adjustments			$ 6,677	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Corporate Fee - Non Reimburable	$ 8,093		
16	1.3	Employee Recognition/Gifts/Parties	$ 1,574		
16	8a	Chamber of Commerce	$ -		
16	m13	User Fee Due per Audit	$ 2,070		
16	m13	Resident Expenses	$ 191		
16	m13	Account Write Off	$ 4,114		
Total Other A&G Adjustments			$ 16,042	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page
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Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	337,201	337,201		
Page 20 - Resident Care Supplies***								
27.			Prescription Drugs	$	3,363	3,363		
28.			Ambulance/Limousine	$	14,694	14,694		
29.			X-rays, etc	$	317	317		
30.			Laboratory	$	129	129		
31.			Medical Supplies	$				
32.			Oxygen (non emergency)	$	358	358		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	75	75		
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$				
36.			Depreciation on Unallowable Motor Vehicles	$				
37.			Unallowable Property and Real Estate Taxes	$				
38.			Rental of Building Space or Rooms	$				
39.			Other - See Attached Schedule	$				
Page 27 - Insurance								
40.			Mortgage Insurance	$				
41.			Property Insurance	$				
Other - Miscellaneous								
42.			Research or Experimental Activities	$				
43.			Radio and Television Revenue	$				
44.			Vending Machine Revenue	$				
45.			Purchase Discounts and Allowances	$				
46.			Duplications of functions or services	$				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	$				
48.	30	IV5	Interest Income on Accounts Rec	$	8	8		
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	$	573	573		
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)***			$	356,718	356,718		

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

Attachment Page 29

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Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	IV Therapy Supplies	$ 75		
20	5j	Rehab Service Supplies	$ -		
Total Other Ancillary Costs			$ 75	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
24	12D	Interest on Value Health Note	$ 573		
Total Other Adjustments			$ 573	$ -	$ -

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
The Kent, LTD	2147-C	9/30/2016	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	872,912	872,912		
b. Medicaid Room and Board Contractual Allowance **	$				
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	(9,224)	(9,224)		
b. Medicare Room and Board Contractual Allowance **	$	1,017	1,017		
4. a. Private-Pay Residents and Other	$	24,471	24,471		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	(2,648)	(2,648)		
b. Prescription Drugs - Medicare Contractual Allowance **	$	2,648	2,648		
c. Prescription Drugs - Non-Medicare	$	2,914	2,914		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(2,914)	(2,914)		
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	$	(140)	(140)		
b. Physical Therapy - Medicare Contractual Allowance **	$	175	175		
c. Physical Therapy - Non-Medicare	$	700	700		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(700)	(700)		
4. a. Speech Therapy - Medicare	$	495	495		
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$				
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	(540)	(540)		
b. Occupational Therapy - Medicare Contractual Allowance **	$	540	540		
c. Occupational Therapy - Non-Medicare	$				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	889,705	889,705		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	8	8		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	4,057	4,057		
V. Total Other Revenue (1 thru 8)	$	4,065	4,065		
VI. Total All Revenue (III +V)	$	893,770	893,770		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30 IV5	Interest Income	705,742	$ 8		
Total Interest Income			$ 8	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30	Fixed Asset adjustment - Prior Period	$ 559		
30	Post Closing - Prior Period Adj	$ 3,498		
Total Other Revenue		$ 4,057	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
The Kent, LTD	2147-C	9/30/2016	31	37

Account					Amount
Assets					
A. Current Assets					
1. Cash (*on hand and in banks*)					$ 12,551
2. Resident Accounts Receivable (Less Allowance for Bad Debts)					$ 705,742
3. Other Accounts Receivable (Excluding Owners or Related Parties)					$
4 Inventories					$ 30,141
5. Prepaid Expenses					$ 11,879
a. Prepaid Insurance		5,324			
b. Prepaid Property Tax		6,555			
c. Prepaid Other					
d.					
6. Interest Receivable					$
7. Medicare Final Settlement Receivable					$
8. Other Current Assets (*itemize*)					$ 606,598
Due Affiliate (Debit Balance)		606,598			
A-9. ***Total Current Assets*** (Lines A1 thru 8)					$ 1,366,911
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	716,154			$ 151,507
	Accum. Depreciation	564,647		Net	
5. Non-Movable Equipment	*Historical Cost	438,532			$ 50,026
	Accum. Depreciation	388,506		Net	
6. Movable Equipment	*Historical Cost	749,656			$ 142,747
	Accum. Depreciation	606,909		Net	
7. Motor Vehicles	*Historical Cost				$
	Accum. Depreciation			Net	
8. Minor Equipment-Not Depreciable					$
9. Other Fixed Assets (*itemize*)					$
Construction in Progress					
Fixed Asset Clearning Account					
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)					$ 344,279

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
The Kent, LTD	2147-C	9/30/2016	32	37

Account				Amount
			Total Brought Forward:	$ 1,711,190
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$
Capitalized Refinance Expense				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 1,711,190

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
The Kent, LTD	2147-C	9/30/2016	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 196,734
2. Notes Payable (*itemize*)	$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)	$ 2,547
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$ 21,876
7. Medicare Final Settlement Payable	$
8. Medicare Current Financing Payable	$
9. Mortgage Payable (*Current Portion*)	$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)	$
11. Accrued Income Taxes*	$
12. Other Current Liabilities (*itemize*)	$ 110,872

Accrued PTO	(0)	Accrued Worker's Comp	85,704
Accrued Pension	838	Accrued Professional Fee	6,317
Accrued Expense Other	12,890		
Payroll W/H	5,123		

A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 332,029

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
The Kent, LTD	2147-C	9/30/2016	34	37

Account	Amount
Total Brought Forward:	332,029
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$ 2,017,288

Name and Address of Lender	Amount	Loan Date
Brian J. Foley	2,017,288	Demand

4. Other Long-Term Liabilities (*itemize*)	$
Security Deposit	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 2,017,288
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 2,349,317

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Kent, LTD	2147-C	9/30/2016	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$ 9,893,787
	2. Capital Stock	$ 1,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (9,901,674)
	6. Gain or Loss for Period 10/1/2015 thru 9/30/2016	$ (631,239)
	7. Total Net Worth	$ (638,126)
C.	***Total Reserves and Net Worth***	$ (638,126)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 1,711,190

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
The Kent, LTD	2147-C	9/30/2016	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2015			$ (2,206,887)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 893,770
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 1,525,009
D.	Net Income or Deficit			$ (631,239)
E.	Balance			$ (2,838,126)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Brian J Foley	2,200,000		
	2. Other (*itemize*)			
F-3.	Total Additions			$ 2,200,000
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period***	09/30/16		$ (638,126)