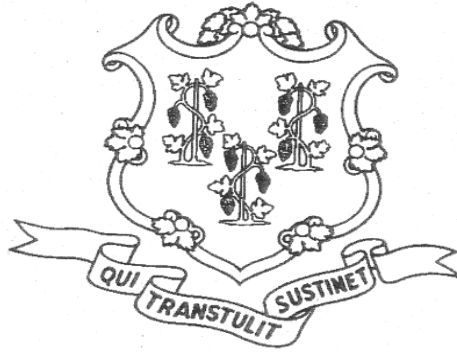


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2017

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 checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

License Numbers:	CCNH 2330	RHNS	(Specify)	Medicare Provider 075208
------------------	--------------	------	-----------	-----------------------------

Medicaid Provider Numbers:	CCNH 8771	RHNS	ICF-IID
----------------------------	--------------	------	---------

**For Department Use Only**

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

# Table of Contents

General Information - Administrator's/Owner's Certification	1
General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
General Information and Questionnaire - Type of Facility - Organization Structure	2
General Information and Questionnaire - Partners/Members	3
General Information and Questionnaire - Corporate Owners	3A
General Information and Questionnaire - Individual Proprietorship	3B
General Information and Questionnaire - Related Parties	4
General Information and Questionnaire - Basis for Allocation of Costs	5
General Information and Questionnaire - Leases	6
General Information and Questionnaire - Accounting Basis	7
Schedule of Resident Statistics	8
Schedule of Resident Statistics (Cont'd)	9
A. Report of Expenditures - Salaries & Wages	10
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B. Report of Expenditures - Professional Fees	13
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C. Expenditures Other than Salaries - Administrative and General	15
C. Expenditures Other than Salaries (Cont'd) - Administrative and General	16
Schedule C-1 - Management Services	17
C. Expenditures Other than Salaries (Cont'd) - Dietary	18
C. Expenditures Other than Salaries (Cont'd) - Laundry	19
C. Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
Depreciation Schedule	23
Amortization Schedule	24
C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C. Expenditures Other than Salaries (Cont'd) - Interest	26
C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D. Adjustments to Statement of Expenditures	28
D. Adjustments to Statement of Expenditures (Cont'd)	29
F. Statement of Revenue	30
G. Balance Sheet	31
G. Balance Sheet (Cont'd)	32
G. Balance Sheet (Cont'd)	33
G. Balance Sheet (Cont'd)	34
G. Balance Sheet (Cont'd) - Reserves and Net Worth	35
H. Changes in Total Net Worth	36
I. Preparer's/Reviewer's Certification	37

### General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
New Milford Crossings LLC DBA Village Crest Center	2330	9/30/2017	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 New Milford Crossings LLC DBA Village Crest Center for Health and Rehabilitation [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, 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) James Noonan			Printed Name (Owner) Marvin J. Ostreicher		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires	
				/ /	
Address of Notary Public					

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility New Milford Crossings LLC DBA Village Crest Center for Health and Rehabilitation		Period Covered:	From 10/1/2016	To 9/30/2017
Address of Facility 19 Poplar St., New Milford, CT 06776				
Report Prepared By Blum Shapiro & Co.		Phone Number 203-944-2100	Date 2/1/2018	
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. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

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

Phone No. of Facility 203-354-9365		Report for Year Ended 9/30/2017	Page 2	of 37
Name of Facility (as shown on license) New Milford Crossings LLC DBA Village Crest Center for Ho		Address (No. & Street, City, State, Zip) 19 Poplar St., New Milford, CT 06776		
License Numbers:	CCNH 2330	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.				
<b>Administrator</b>				
Name of Administrator James Noonan		Nursing Home Administrator's License No.:	001100	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		



**New Milford Crossings, LLC**  
**Page 3 Attachment**

<b>Owner</b>	<b>Ownership Percentage</b>
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/>
	<b>100.000%</b>







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

Name of Facility New Milford Crossings LLC DBA Village Crest Center	License No. 2330	Report for Year Ended 9/30/2017	Page 4	of 37
--	---------------------	------------------------------------	-----------	----------

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?     Yes     No    If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
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 9/30/2017	Page 4	of 37
--	---------------------	------------------------------------	-----------	----------

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?  Yes  No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Preferred Therapy	850 Silas Deane Hwy, Wethersfield, Ct 06109	<input checked="" type="checkbox"/>	<input type="checkbox"/>	37%	PT,OT,ST Services/Consulting	13 5a,9a,10a,12	438,634	433,305
NOA Diagnostics	6851 Jericho Turnpike, Suite 150 Syosset, NY 11791	<input checked="" type="checkbox"/>	<input type="checkbox"/>	82%	Radiology	20 5f	11,999	11,081
National Health Care Associates - Aetna	850 Silas Deane Hwy, Wethersfield, Ct 06109	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Health Insurance Trust***	15 1a5	507,303	507,303
National Health Care Associates	20 East Sunrise Highway, Valley Stream, NY 11581	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Banking Transactions	16 M13	15,473	15,473
EP New Milford Realty, LLC	850 Silas Deane Hwy, Wethersfield, Ct 06109	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Rent	22 9	369,792	369,792
National Health Care Associates	20 East Sunrise Highway, Valley Stream, NY 11581	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Shared Expenses	16 12/13	401,222	401,222
850 Silas Deane	850 Silas Deane Hwy, Wethersfield, Ct 06109	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Shared Expenses	16 12	1,378	1,378
20 Sunrise	20 East Sunrise Highway, Valley Stream, NY 11581	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Shared Expenses	16 12	7,572	7,572
Stauderman Realty	46 Stauderman Ave, Lynbrook NY 11563	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Shared Expenses	16 12	188	188
Procure LTC Pharmacy Of MA LLC	155 Northboro Rd STE 4 Southborough MA 01772	<input checked="" type="checkbox"/>	<input type="checkbox"/>	92%	Drugs	20 5a2	528	472
Procure LTC Pharmacy of CT LLC	1492 Highland Ave Cheshire CT 06410	<input checked="" type="checkbox"/>	<input type="checkbox"/>	92%	Drugs/OTC's/Supplies/Consult/Fees	20/13 5a2,b,j/b3,12	211,045	188,771

\* 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  
Related Parties\***

Name of Facility New Milford Crossings LLC DBA Village Crest Center for Health and Rehabilitation	License No. 8771	Report for Year Ended 9/30/2017	Page 4	of 37
--	---------------------	------------------------------------	-----------	----------

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?  Yes  No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Bristol Crossings LLC	61 Bellevue Ave, Bristol, CT 06010	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Due from Related	31 A8	3,624	3,624
National Health Care Associates - Aetna	850 Silas Deane Highway, Wethersfield, CT 06109	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Accounts payable	33 A1	64,264	64,264
EP New Milford Realty, LLC	850 Silas Deane Hwy, Wethersfield, Ct 06109	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Due to Related	33 A12	507,283	507,283
Preferred Therapy Solutions	850 Silas Deane Highway, Wethersfield, CT 06109	<input checked="" type="checkbox"/>	<input type="checkbox"/>	37%	Due to Related	33 A12	13,081	13,081
NOA Diagnostics	6851 Jericho Turnpike, Suite 150 Syosset, NY 11791	<input checked="" type="checkbox"/>	<input type="checkbox"/>	82%	Due to Related	33 A12	1,675	1,675
National Health Care Associates	20 East Sunrise Highway, Valley Stream, NY 11581	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Due to Related	33 A12	22,104	22,104
National Health Care Associates	20 East Sunrise Highway, Valley Stream, NY 11581	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Due to Related (Debt)	33 A12	104,354	104,354
Cold Spring Hills Center for Nursing & Rehabilitation	378 Syosset-Woodbury Rd, Woodbury, NY 11797	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Due to Related	33 A12	4,382	4,382
Procare LTC Pharmacy of CT	1492 Highland Ave Cheshire CT 06410	<input checked="" type="checkbox"/>	<input type="checkbox"/>	92%	Due to Related	33 A12	81,250	81,250
Milford Health Care Center, Inc.	195 Platt Street, Milford, CT 06460	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Due to Related	33 A12	12,297	12,297

\* 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 Crest	License No. 2330	Report for Year Ended 9/30/2017	Page 5	of 37
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? <input checked="" type="radio"/> Yes <input type="radio"/> 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 and geographical location. 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.)				
<input checked="" type="radio"/> Yes <input type="radio"/> 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 I			2330	9/30/2017			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, Nostrand Ave, Brooklyn, NY 11230	<input type="radio"/>	<input checked="" type="radio"/>	Computer Equipment	10/01/08	60 / ongoing	4,324		4,324
Wescom Solutions, PO Box 674802, Detroit, MI 48267	<input type="radio"/>	<input checked="" type="radio"/>	Software	Ongoing	Ongoing	16,387		16,387
CIT Finance LLC, 10201 Centurion Parkway N.#100 Jacksonville FL 32256	<input type="radio"/>	<input checked="" type="radio"/>	Copier	07/21/15	39 months	5,216		4,963
De Lage Landen #501862 P.O. Box 41602, Philadelphia, PA, 19101	<input type="radio"/>	<input checked="" type="radio"/>	Copier	11/30/16	36 Months	3,394		3,146
	<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"/>						
							<b>Total ***</b>	28,820

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.

**De Lage Landen Financial Services, Inc.**

**Lease Agreement  
# FTN82094-001**

LESSEE	Full Legal Name NEW MILFORD CROSSING LLC			Phone Number 8603549365		
	Billing Address 19 POPLAR ST, NEW MILFORD, CT, 06776			Attention to		
Send Email Invoice to:				Purchase Order Requestion Number		
EQUIPMENT	Equipment Make	Model Number	Serial Number	Quantity	Description (Attach separate Schedule A if Necessary)	
	Toshiba	e-Studio 4508a		1		
	Toshiba	e-Studio 3055c		1		
PAYMENT INFORMATION	Number of Lease Payments	Lease Payment	Plus Applicable Taxes	Term of Lease in Months	End of Lease Option	Payment Frequency
	39	265.94	* per mth	39	Fair Market Value	Monthly
		*	Plus Applicable Taxes		End of Lease Purchase Option shall be FMV unless another option is indicated.	
Lease Payment <input type="checkbox"/> includes / <input type="checkbox"/> does NOT include maintenance/service/supplies [check one]				First Period Payment	(PLUS) Other	(EQUALS) Total Payment Enclosed
*Lease payment may be adjusted for front sales tax.					+	=

1. Lease: You (the "Lessee") agree to lease from us (the "Lessor") the above Equipment and on any attached schedule (the "Lease"). You authorize us to adjust the Lease payments by up to 15% if the cost of the Equipment or taxes differs from the supplier's estimate. This Lease is effective on the date that it is accepted and signed by us, and the term of this Lease begins on that date or any later date that we designate (the "Commencement Date") and continues thereafter for the number of months indicated above. Lease payments are due as invoiced by us. As you will have possession of the Equipment from the date of its delivery, if we accept and sign this Lease you will pay us interim rent for the period from the date the Equipment is delivered to you until the Commencement Date, as reasonably calculated by us based on the Lease payment, the number of days in that period, and a month of 30 days. Your Lease obligations are absolute, unconditional and are not subject to cancellation, reduction, setoff or counterclaim. You agree to pay us a fee of \$75 to reimburse our expenses for preparing financing statements, other documentation costs and all ongoing administration costs during the Lease term. If a payment is not made when due, you will pay us a late charge of 10% of the payment or \$10, whichever is greater. We will charge you a fee of \$25 for any check that is returned. We may increase the Lease Payment on an annual basis, in an amount not to exceed ten percent (10%) of the Lease Payment in effect at the end of the prior annual period. YOU AGREE THAT NO ONE IS AUTHORIZED TO WAIVE OR CHANGE ANY TERM OR CONDITION OF THE LEASE.

2. Title: Unless you have a \$1.00 purchase option, we will have title to the Equipment. If you have a \$1.00 purchase option and/or the lease is deemed to be a security agreement, you grant us a security interest in the Equipment and all proceeds thereof. You authorize us to file Uniform Commercial Code ("UCC") financing statements on the Equipment.

3. Equipment Use, Maintenance and Warranties: We are leasing the Equipment to you "AS-IS" AND MAKE NO WARRANTIES, EXPRESS OR IMPLIED, INCLUDING WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE. We transfer to you any manufacturer warranties. You are required at your cost to keep the Equipment in good working condition and to pay for all supplies and repairs. The above Lease Payments do not include the cost of maintenance, service, and/or supplies ("Service"), unless indicated in the above "Payment Information" box. Notwithstanding anything to the contrary, you agree that we are not responsible for providing such Service for the Equipment and you will make all claims related to Service to the Service provider ("Provider"). No Provider may alter the terms of this Lease or make any promises or arrangements that alter our rights or your obligations under this Lease. You agree that you are expressly assuming any risks arising from such Provider's inability to deliver such Service, under any circumstance, including, without limitation, such Provider's financial condition or its inability to repair or service the Equipment. You agree that any Service claims will not impact your obligation to pay all Lease payments when due.

4. Assignment: You agree not to transfer, sell, sublease, assign, pledge or encumber either the Equipment or any rights under this Lease without our prior written consent. You agree that we may sell, assign, or transfer the Lease and the new owner will have the same rights and benefits we now have and will not have to perform any of our obligations and the rights of the new owner will not be subject to any claims, defenses, or setoffs that you may have against us or any supplier.

5. Risk of Loss and Insurance: You are responsible for all risks of loss or damage to the Equipment and if any loss occurs you are required to satisfy all of your Lease obligations. You will keep the Equipment insured against all risks of loss or damage for an amount equal to its replacement cost. You will list us as the sole loss payee for the insurance and give us written proof of the insurance. If you do not provide such insurance, you agree that we have the right, but not the obligation, to obtain such insurance, and add an insurance fee to the amount due from you, on which we may make a profit. We are not responsible for any losses or injuries caused by the Equipment and you will reimburse us and defend us against any such claims. This indemnity will continue after the termination of this Lease. You will obtain and maintain comprehensive public liability insurance naming us as an additional insured with coverages and amounts acceptable to us.

6. Taxes: You agree to pay when due, either directly or as reimbursement to us, all taxes (including, without limit, sales, use and personal property) and charges in connection with ownership, lease and use of the Equipment. We may charge you a processing fee for

administering property tax filings. You will indemnify us on an after-tax basis against the loss or unavailability of any tax benefits anticipated at the Commencement Date arising out of your acts or omissions. This indemnity will continue even after the termination of this Lease.

7. End of Lease, Return, Purchase Option, and Renewal: You will give us at least 60 days but not more than 120 days written notice (to our address below) before the expiration of the initial Lease term (or any renewal term) of your intention to purchase or return the Equipment. With proper notice you may: a) purchase all the Equipment as indicated above under "End of Lease Option" (fair market value purchase option amounts will be determined by us based on the Equipment's in place value); or b) return all the Equipment in good working condition at your cost in a timely manner, and to a location we designate. If you fail to notify us, or if you do not (i) purchase or (ii) return the Equipment as provided herein, this Lease will automatically renew at the same payment amount for consecutive 60-day periods. If the Equipment is returned to us, you shall remove all confidential information from the Equipment prior to return. If any software license ("License") included hereunder passes title to you, such title shall automatically vest and remain in us.

8. Default and Remedies: You are in default on this Lease if: a) you fail to pay a Lease payment or any other amount when due; or b) you breach any other obligation under the Lease or any other Lease with us. If you are in default on the Lease we may: (i) declare the entire balance of unpaid Lease payments for the full Lease term immediately due and payable to us; (ii) sue you for and receive the total amount due on the Lease plus the Equipment's anticipated end of Lease fair market value or fixed price purchase option (the "Residual") with future Lease payments and the Residual discounted to the date of default at 6% per annum, plus reasonable collection and legal costs; (iii) charge you interest on all monies due at the rate of 18% per year or the highest rate permitted by law from the date of default; (iv) charge you a return-check or non-sufficient funds charge ("NSF Charge") of \$25.00 for a check that is returned; and (v) require that you immediately return the Equipment to us or we may peaceably repossess it. Any return or repossession will not be considered a termination or cancellation of the Lease. If the Equipment is returned or repossessed we will sell or re-rent the Equipment at terms we determine, at one or more public or private sales, with or without notice to you, and apply the net proceeds (after deducting any related expenses) to your obligations. You remain liable for any deficiency with any excess being retained by us. You agree that if notice of sale is required by law to be given, 10 days notice will constitute reasonable notice. You are also required to pay (i) all expenses incurred by us in connection with enforcement of any remedies, including all expenses of repossessing, storing, shipping, repairing, and selling the Equipment, and (ii) reasonable attorney's fees.

9. Miscellaneous: You agree the Lease is a Finance Lease as defined in Article 2A of the UCC. You acknowledge we have given you the name of the Equipment supplier and that you may have rights under the contract with the supplier and may contact the supplier for a description of these rights. This Lease was made in Pennsylvania ("PA"), is to be performed in PA and shall be governed and construed in accordance with the laws of PA. You consent to jurisdiction, personal or otherwise, in any state or federal court in PA and irrevocably waive a trial by jury. You agree (i) to waive any and all rights and remedies granted to you under UCC Section 2A-508 through 2A-522, (ii) that the Equipment will only be used for business purposes and not for personal, family, or household use, and will not be moved from the above location without our consent, and (iii) this Lease may be executed in counterparts and any facsimile, photographic or other electronic transmission and/or electronic signing of this Lease by you when manually countersigned by us or attached to our original signature counterpart and/or in our possession shall constitute the sole original chattel paper as defined in the UCC for all purposes and will be admissible as legal evidence thereof. At our option, we may require a manual signature. We may inspect the Equipment during the Lease term. We shall not be liable to you for indirect, special, or consequential damages. No failure to act shall be deemed a waiver of any rights hereunder. You authorize us and our agents to contact you about all of your accounts with us in any way, such as calling, texting, or using an automated dialer, at any number or email address you have provided to us, from which you have contacted us, or at which we believe we can reach you, even if you are charged for such contact by a provider.

You agree that this is a non-cancelable lease. The Equipment is:  NEW  USED

LESSEE SIGNATURE	Signature	Date
	Title	Print Name
Legal Name of Corporation NEW MILFORD CROSSING LLC		

LESSOR	<b>DE LAGE LANDEN FINANCIAL SERVICES, INC.</b>	
	Lease Processing Cnt: 1111 Old Eagle School Road, Wayne, PA 19087-8608 Phone: (800) 735-3273 • Fax: (800) 776-2329	
	Commencement Date	Lease Number
Accepted By:		

ACCEPTANCE	The Equipment has been received, put in use, is in good working order and is satisfactory and acceptable.		
	Signature	Date	Title

**THE OFFICE WORKS**

The Office Works, Inc.  
 45 Corporate Avenue  
 Plainville, CT 06062  
 1-800-634-4810 1-860-793-9994

DATE: 9-30-16

**BILL TO:**  
 Village Crest Center for Health  
 19 Poplar Street  
 New Milford, CT 06776

**SHIP TO:**  
 Same

ITEM	DESCRIPTION	QTY	UNIT PRICE	EXTENDED PRICE
e-Studio 4508A	Toshiba color multifunctional copier	1		
MR3031	Automatic document handler	1		
KD1059LT	Large capacity paper feed pedestal	1		39-month lease \$265.94 per month
e-Studio 3055C	Toshiba color multifunctional copier	1		
MR3025	Automatic document handler	1		
KD1031	Large capacity paper feed pedestal	1		
GD1320NX	Fax board	1		
			<b>TOTAL SALE</b>	Lease
			<b>DELIVERY CHARGE</b>	N/C
			<b>SALES TAX</b>	6.35% of mo. payment
			<b>TOTAL DUE</b>	N/A

**Notes / Provisions**

- Lease cost includes delivery, installation and training.
- The two new copying systems will be added to the current maintenance agreement.

**CUSTOMER:** Village Crest Center for Health

**THE OFFICE WORKS, INC.**

Authorized Signature 

Accepted By \_\_\_\_\_

Print Name Michael Bobrow

Print Name \_\_\_\_\_

Title \_\_\_\_\_

Title \_\_\_\_\_

Date 10/6/16

Phone \_\_\_\_\_

Sales Associate \_\_\_\_\_



**General Information and Questionnaire**  
**Accounting Basis**

Name of Facility New Milford Crossings LLC DBA	License No. 2330	Report for Year Ended 9/30/2017	Page 7	of 37
---	---------------------	------------------------------------	-----------	----------

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) 2 Enterprise Dr, Shelton, CT 06484
---	---

Services Provided by This Firm ( <i>describe fully</i> )	
1 Review, preparation of Medicare and Medicaid cost reports, and year end tax services	\$ 26,640
2	\$
3	\$
4	\$
	<b>Charge for Services Provided</b>
	\$ 26,640

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.  
 Yes     No    Page 15, line 1d

**Legal Services Information**

Name of Legal Firm or Independent Attorney 1 Goldman Gruder & Wood 2 Treasurer State of Connecticut 3 Marshal Tim Poeti 4 Corporation Service Company 5 Rogin Nassau	Telephone Number (203) 899-8900     (860) 256-6300
---	--

Address ( <i>No. &amp; Street, City, State, Zip Code</i> )	
1 200 Connecticut Ave Norwalk CT 06854	
2	
3	
4 251 Little Falls Drive, Wilmington, DE 19808-1674	
5 185 ASYLYM STREET -22ND FLOOR HARTFORD CT 06103-3460	

Services Provided by This Firm ( <i>describe fully</i> )	
1 Collections - Disallow	\$ 8,500
2 Conservator - Disallow	\$ 900
3 Conservator - Disallow	\$ 165
4 Revaluation - Disallow	\$ 142
5 Revaluation - Disallow	\$ 578
	<b>Charge for Services Provided</b>
	\$ 10,285

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 F			2330		9/30/2017				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	70	70			70	70			84	84		
B. As of midnight of THIS report period	77	77			84	84			77	77		
3. Total Number of Days Care Provided During Period												
A. Medicare	3,403	3,403			2,601	2,601			802	802		
B. Medicaid (Conn.)	22,448	22,448			16,634	16,634			5,814	5,814		
C. Medicaid (other states)												
D. Private Pay	1,871	1,871			1,377	1,377			494	494		
E. State SSI for RCH												
F. Other (Specify) Managed Care	140	140			100	100			40	40		
G. Total Care Days During Period (3A thru F)	27,862	27,862			20,712	20,712			7,150	7,150		
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	6	6			5	5			1	1		
5. <b>Total Resident Days (3G + 4A + 4B)</b>	27,868	27,868			20,717	20,717			7,151	7,151		

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

Name of Facility New Milford Crossings LLC DBA Village Cr			License No. 2330			Report for Year Ended 9/30/2017			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	(Specify)	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR			
No. of Residents	10		58			9							
Per Diem Rate													
a. One bed rm.	PPS		234.32			425/480							
b. Two bed rms.	PPS		234.32			390/450							
c. Three or more bed rms.	PPS					355/405							
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									2,295	2,295			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									425	425			
C. Other									10,105	10,105			
D. <b>Total Physical Therapy Treatments</b>									12,825	12,825			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									171	171			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									27	27			
C. Other									616	616			
D. <b>Total Speech Therapy Treatments</b>									814	814			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									1,225	1,225			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									292	292			
C. Other									8,729	8,729			
D. <b>Total Occupational Therapy Treatments</b>									10,246	10,246			

### Report of Expenditures - Salaries & Wages

Name of Facility New Milford Crossings LLC DBA Village Crest Center for He	License No. 2330	Report for Year Ended 9/30/2017	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
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	133,357	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	178,671	9,445				
5. Dietary Service						
a. Head Dietitian	31,129	749				
b. Food Service Supervisor	46,718	2,200				
c. Dietary Workers	284,078	19,206				
6. Housekeeping Service						
a. Head Housekeeper	43,224	1,985				
b. Other Housekeeping Workers	206,557	13,946				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	39,879	1,528				
b. Other Maintenance Workers	32,419	2,117				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	79,441	5,654				
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	119,697	2,518				
b. RN						
1. Direct Care	387,929	10,392				
2. Administrative**	146,823	3,366				
c. LPN						
1. Direct Care	767,533	29,406				
2. Administrative**						
d. Aides and Attendants	988,352	64,811				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	90,392	4,685				
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	104,444	3,556				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	3,680,643	177,644				

\* 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 and Re				2330	9/30/2017				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)							
<b>Section I - Operators/Owners</b>										
Marvin J. Ostreicher, 184 Wildacre Ave, Lawrence, NY 11559				same as employees	Supervises operations, deals with DNS & other	48	Page 16, 1m13-\$31,200	See attached		
<b>Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).</b>										

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

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

MARVIN J. OSTREICHER - OWNER  
 TIME STUDY  
 YEAR END SEPTEMBER 30, 2017

Name	Beds	Total w/ Bnft
Augusta	72	53.82
Belair	102	52.61
Bethel	161	76.49
Bloomfield	120	55.03
Brattleboro	80	58.96
Brentwood	78	36.58
Brewer	111	67.73
Bristol	132	64.40
Cambridge	160	45.65
Catskill	136	51.40
Cold Spring Hills	-	-
Colony	92	44.44
Country	111	43.24
Dover	112	61.98
Eastside	69	48.07
Eliot	114	68.33
Glen Falls	120	48.68
Hudson	-	-
Huntington	320	54.42
Kennebunk	78	55.63
Hebrew Home	257	60.77
Ludlowe	144	65.00
Maple View	120	59.26
Marlborough	120	60.47
Maywood	120	47.47
Milford	120	52.00
Newton Wellseley	110	54.42
Norway	70	53.51
Poughkeepsie	200	63.19
Regency	130	48.68
Reservoir	144	53.51
Riverside	345	50.19
Ross	135	-
Rutland	125	55.93
Sachem	111	59.56
Sands Point	180	67.42
Utica	117	54.42
Village Crest	95	48.38
Water's Edge	150	57.75
Westgate	104	52.00
Winship	72	51.10
Total	5,137	2,102.50
Vacation		
Sick		
Personal		
Holiday		
Total Hours		

**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				2330	9/30/2017			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)							
<b>Section III - Administrators***</b>										
James Noonan	133,357			same as employees	Management & supervision of healthcare	2,080	a2			
<b>Section IV - Assistant Administrators</b>										

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

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

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



**Annual Report of Long-Term Care Facility**

**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	2330	9/30/2017	13	37		
<b>Total Cost and Hours</b>						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian						
2. Dentist	7,110	Disallowed				
3. Pharmacist	10,594	Disallowed				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	226,172	4,201				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	57,300	216				
b. Utilization Review (Title 18 and 19 only) monthly meeting	260	3				
c. Resident Care**	794	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	29,666	498				
b. Other						
10. Occupational Therapist						
a. Resident Care	181,577	3,207				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	141,062	1,941				
2. Administrative***						
b. LPN						
1. Direct Care	78,042	1,703				
2. Administrative***						
c. Aides	1,392	60				
d. Other						
12. Other (Specify) See Attached Schedule	6,126	Disallowed				
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>740,095</b>	<b>11,829</b>				

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

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

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

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

Name of Facility New Milford Crossings LLC DBA Village Crest Center		License No. 2330	Report for Year Ended 9/30/2017	Page 14	of 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, 111 Executive Blvd, Farmingdale, NY 11735	Pharmacist , Consulting - Nursing	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	
Preferred Therapy, 850 Silas Deane Highway, Wethersfield, CT 06109	PT, OT, ST, Consulting - Rehab, 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"/>		
SDX/Swallowing Diagnostic, PO Box 484, Avon, CT 06001	ST	<input type="radio"/>	<input checked="" type="radio"/>		
New Milford Family Practice 1 Old Park Lane New Milford, CT 06776-2507	Utilization Review	<input type="radio"/>	<input type="radio"/>		
Danbury Hostipal 19 Poplar Street New Milford, CT 06776	Resident Care	<input type="radio"/>	<input type="radio"/>		
360 Healthcare Staffing P.O. Box 674009 Dallas, TX 75267-4009	RN'S	<input type="radio"/>	<input checked="" type="radio"/>		
AAA Nursing Care 3303 Main Street Stratford, CT 06614	RN,LPN's	<input type="radio"/>	<input checked="" type="radio"/>		
Maxim Healthcare Services DBA Maxim Staffing Solutions 1344 Silas Deane Hwy #510, Rocky	RN,LPN's	<input type="radio"/>	<input checked="" type="radio"/>		
The Nurse Network 653 Main Street Plantsville, CT 06479	RN,LPN's	<input type="radio"/>	<input checked="" type="radio"/>		
Geronnursing Northwest, Inc. P.O.Box 552 New Milford, CT 06776	RN,LPN's	<input type="radio"/>	<input checked="" type="radio"/>		
Preferred Professional Service 850 Silas Deane Highway Wethersfield, CT 06109	CNA'S	<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	2330	9/30/2017	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 181,409	181,409		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 74,764	74,764		
4. Social Security (F.I.C.A.)	\$ 273,073	273,073		
5. Health Insurance	\$ 507,303	507,303		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 7,000	7,000		
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	\$ 26,640	26,640		
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 10,285	10,285		
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$			
g. Office Supplies	\$ 19,616	19,616		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 29,729	29,729		
2. Cellular Phones	\$ 1,591	1,591		
i. Appraisal ( <i>Specify purpose and         attach copy</i> )*	\$			
j. Corporation Business Taxes ( <i>franchise tax</i> )	\$ 251	251		
k. Other Taxes ( <i>Not related to property - See Page 22</i> )				
1. Income*	\$			
2. Other ( <i>Specify</i> ) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 514,254	514,254		
<b>Subtotal</b>	<b>\$ 1,645,915</b>	<b>1,645,915</b>		

\* 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	2330	9/30/2017	16	37	
Item		Total	CCNH	RHNS	(Specify)
<b>Subtotals Brought Forward:</b>		1,645,915	1,645,915		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	1,070	1,070		
3. Gifts to Staff and Residents	\$	3,395	3,395		
4. Employee Travel	\$	13,008	13,008		
5. Education Expenses Related to Seminars and Conventions	\$	1,169	1,169		
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$	557	557		
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$				
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	30,156	30,156		
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	\$	2,816	2,816		
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	6,898	6,898		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	280	280		
9. Subscriptions	\$	3,919	3,919		
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**	\$	397,514	397,514		
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	276,015	276,015		
<b>C-14 Total Administrative &amp; General Expenditures</b>		\$ 2,382,712	2,382,712		

\* 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)
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
Advertising Promotional - Marketing	\$ 22,860		
Advertising Promotional - Administration	\$ 7,296		
<b>Total Other Advertising</b>	\$ 30,156	\$ -	\$ -

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 6,898		
<b>Total Dues</b>	\$ 6,898	\$ -	\$ -

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
<b>Total Contributions</b>	\$ -	\$ -	\$ -

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
Consulting Fees - Fiscal Operations	\$ 1,211		
Purchased Services - Fiscal Operations	\$ 37,234		
Purchased Services - Admin Staff	\$ 31,200		
Licenses and Permits - Administration	\$ 1,065		
Background Check - Administration and Security	\$ 5,569		
Penalties - Administration - Disallowed	\$ 10		
Bank Charges - Administration - Disallowed	\$ 19,726		
Crime Insurance - Administration - Disallowed	\$ 835		
Consulting Fees - Administration - Disallowed via management fee	\$ 12,846		
IT Services - Fiscal Operations	\$ 49,136		
Misc. Expense - Administration - Disallowed	\$ 27,980		
Consulting Fees - Admissions	\$ 771		
Amortization of Goodwill- Disallowed	\$ 88,432		
<b>Total Other Administrative and General</b>	\$ 276,015	\$ -	\$ -

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

Name of Facility New Milford Crossings LLC DBA Village	License No. 2330	Report for Year Ended 9/30/2017	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	397,514	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.**





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

Name of Facility		License No.	Report for Year Ended		Page	of
New Milford Crossings LLC DBA Village Crest Center		2330	9/30/2017		18	37
Item		Total	CCNH	RHNS	(Specify)	
2. Dietary						
a. In-House Preparation & Service						
1. Raw Food	\$	204,582	204,582			
2. Non-Food Supplies	\$	25,105	25,105			
3. Other (Specify) _____	\$					
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)						
c. Management Services**						
d. Other (Specify) _____						
<b>2E. Total Dietary Expenditures (2a + b + c + d)</b>		\$	229,687	229,687		
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 f		2330	9/30/2017		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. \$	12,130	12,130		
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 ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )		\$	771	771		
c. Management Services**		\$				
d. Other ( <i>Specify</i> ) Diapers \$30,085; Supplies \$3,174		\$	33,259	33,259		
3E. <b>Total Laundry Expenditures</b> (3a + b + c + d)		\$	46,160	46,160		
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		2330	9/30/2017		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. \$	22,148	22,148		
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.	<b>Total Housekeeping Expenditures</b> (4a + b + c + d)	\$	22,148	22,148		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from	\$	184,589	184,589		
b.	Medicine Cabinet Drugs	\$	18,158	18,158		
c.	Medical and Therapeutic Supplies	\$	79,643	79,643		
d.	Ambulance/Limousine***	\$	4,297	4,297		
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	10,034	10,034		
f.	X-rays and Related Radiological Procedures***	\$	12,510	12,510		
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h.	Laboratory***	\$	18,931	18,931		
i.	Recreation	\$	16,254	16,254		
j.	Other (Specify)**** See Attached Schedule	\$	25,749	25,749		
5K.	<b>Total Resident Care Expenditures</b> (5a - 5j)	\$	370,165	370,165		

\* 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**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>(Specify)</b>
Purchased Services - Nursing	\$ 2,129		
Equipment Rental - Nursing	\$ 4,065		
Equipment Rental - Rehabilitation, Therapy & Ancillary	\$ 14,565		
IV Therapy - Rehabilitation, Therapy & Ancillary	\$ 1,750		
Flu Vaccine - Medical Services	\$ 3,240		
<b>Total Other Resident Care</b>	\$ 25,749	\$ -	\$ -

-----

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

Name of Facility			License No.	Report for Year Ended	Page of					
New Milford Crossings LLC DBA Village Crest Center for Health and Reh			2330	9/30/2017	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 / Equipment Rental	20,357			22	6f
ADP	PO Box 842875, Boston, MA 02284	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Processing	11,503			16	m13
Integrated Health Systems	PO Box 23072 Overland Park, KS 66283	<input type="radio"/>	<input checked="" type="radio"/>		Computer Systems Maintenance	14,811			16	m13
Mike and Karens Lawns Unlimited, LLC	186 Cornwall Rd Warren, CT 06754	<input type="radio"/>	<input checked="" type="radio"/>		Landscaping	15,336			22	6f
		<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"/>							
		<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	2330	9/30/2017			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 76,651	76,651				
b. Heat	\$ 15,866	15,866				
c. Light & Power	\$ 167,699	167,699				
d. Water	\$ 42,017	42,017				
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 28,820	28,820				
f. Other ( <i>itemize</i> )	\$ 43,044	43,044				
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	<b>\$ 374,097</b>	<b>374,097</b>				
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 33,106	33,106				
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$ 33,106</b>	<b>33,106</b>				
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 77,503	77,503				
d. Other ( <i>Specify</i> )	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	<b>\$ 77,503</b>	<b>77,503</b>				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 369,792	369,792				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 76,918	76,918				
c. Personal property taxes	\$ 4,938	4,938				
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$ 562,257</b>	<b>562,257</b>				

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

**Schedule of Other Repairs and Maintenance**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>(Specify)</b>
Ground Services - Maintenance	\$ 17,165		
Pest Control - Maintenance	\$ 1,994		
Carting - Maintenance	\$ 17,805		
Purchased Services- Security	\$ 1,210		
Equipment Rental - Maintenance	\$ 2,552		
Equipment Rental - Dietary	\$ 1,753		
IT Rentals	\$ 565		
<b>Total Other Repairs and Maintenance</b>	\$ 43,044	\$ -	\$ -

-----

### Depreciation Schedule

Name of Facility New Milford Crossings LLC DBA Village Crest Center for Health and R				License No. 2330			Report for Year Ended 9/30/2017			Page 23	of 37		
Property Item				Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals		
<b>A. Land Improvements</b>													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal													
<b>B. Building and Building Improvements</b>													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal													
<b>C. Non-Movable Equipment</b>													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal													
		Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
Yes	No	Month	Year										
<b>D. Movable Equipment</b>													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a. Honda Odyssey				X		April	2014	15,661	15,661	9,788	4	3,915	
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period								170,937	170,937	76,043	SL	Various	19,413
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)								134,689	134,689		SL	Various	9,778
D-3. Subtotal													33,106
<b>E. Total Depreciation</b>													33,106



New Milford Crossings LLC DBA Village Crest Center for Health and Rehabilitation  
9/30/2017

**Schedule of Land Improvements Acquired during this report period**

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

\*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
<b>Additions:</b>				
<b>Total additions for Building Improvements</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
<b>Total additions for Non-Movable Equipment</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
11/30/2016	LG Smart LED TV & Samsung LED TV	\$ 589	5	\$ 108
1/31/2017	Dish Dispenser, heated	\$ 3,130	10	\$ 235
1/31/2017	Security Cameras	\$ 1,749	5	\$ 262
5/31/2017	Projector	\$ 585	5	\$ 49
7/31/2017	4 LED TVs	\$ 727	5	\$ 36
8/31/2017	Induction mobile cooking station	\$ 8,599	10	\$ 143
5/31/2017	Integrated Health System - Chromebooks, Servers, Software	\$ 104,355	5	\$ 8,696
8/31/2017	70 Overbed tables	\$ 14,280	10	\$ 238
9/30/2017	Digital Transmitters	\$ 675	5	\$ 11
<b>Total additions for Movable Equipment</b>		\$ 134,689		\$ 9,778 *
<b>Deletions:</b>				
<b>Total deletions for Movable Equipment</b>		\$ -		\$ - **

\*Ties to Page 23, Line D2c

\*\*Ties to Page 23, Line D2b

## Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
11/30/2016	GE Aonline PTAC heat pump	\$ 1,491	10	\$ 137
11/30/2016	GE Aonline PTAC heat pump	\$ 745	10	\$ 68
1/31/2017	Call Bell System	\$ 52,842	10	\$ 3,963
1/31/2017	Wall cover head walls	\$ 10,531	5	\$ 1,580
1/31/2017	Wall bumpers	\$ 41,824	5	\$ 6,274
1/31/2017	Receiving Exterior Door	\$ 2,678	20	\$ 100
1/31/2017	Roof Renovations	\$ 153,750	10	\$ 11,531
2/28/2017	White Vinyl Siding	\$ 102,497	10	\$ 6,833
3/31/2017	2 GE Zonline heat pumps	\$ 1,502	5	\$ 175
6/30/2017	Exterior painting	\$ 39,419	5	\$ 2,628
6/30/2017	Refurbishment of 2 elevators	\$ 169,360	20	\$ 2,823
1/31/2017	Conduct Wiring Roof Lighting	\$ 4,351	15	\$ 218
6/30/2017	Fire protection- sprinklers	\$ 9,731	25	\$ 130
6/30/2017	Conduct Wiring - Elevator	\$ 7,704	20	\$ 128
6/30/2017	Conduct Wiring - Elevator	\$ 7,704	20	\$ 128
6/30/2017	Elevator fire alarm system	\$ 20,589	10	\$ 686
8/31/2017	Patient Room Cabinet	\$ 86,913	10	\$ 1,449
3/31/2017	Inverted box pleat valance - curtains	\$ 10,168	5	\$ 1,186
1/31/2017	Cubicle curtains	\$ 6,392	5	\$ 959
1/31/2017	Cubicle curtains	\$ 4,813	5	\$ 722
1/31/2017	Painting	\$ 5,651	5	\$ 848
1/31/2017	Painting	\$ 5,965	5	\$ 895
1/31/2017	Painting	\$ 6,279	5	\$ 942
1/31/2017	Painting	\$ 6,279	5	\$ 942
2/28/2017	Painting	\$ 5,337	5	\$ 712
3/31/2017	Painting	\$ 6,593	5	\$ 769
4/30/2017	Painting	\$ 5,651	5	\$ 565
5/31/2017	Painting	\$ 6,907	5	\$ 576
6/30/2017	Painting	\$ 6,593	5	\$ 440
7/31/2017	Painting	\$ 3,767	5	\$ 188
8/31/2017	Painting	\$ 5,651	5	\$ 188
9/30/2017	Painting	\$ 6,646	5	\$ 111
9/30/2017	Painting	\$ 4,245	5	\$ 71
<b>Total additions for Leasehold Improvement</b>		\$ 810,568		\$ 48,965 *
<b>Deletions:</b>				

<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ -

\*\*

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

---

**Amortization Schedule\***

Name of Facility			License No.		Report for Year Ended			Page	of
New Milford Crossings LLC DBA Village Crest Center for H			2330		9/30/2017			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							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period				371,964	106,816	SL		28,538	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				810,568		SL		48,965	
C-4. Subtotal									77,503
<b>D. Total Amortization</b>									77,503

\* 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. 2330	Report for Year Ended 9/30/2017	Page 25	of 37
<b>11. Property Questionnaire</b>				
<b>Part A</b>				
Is the property either owned by the Facility or leased from a Related Party?*		<input 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		08/01/68		
2. Date Structure Completed		06/01/71		
3. If <b>NOT</b> Original Owner, Date of Purchase		02/01/08		
4. Date of Initial Licensure		06/01/71		
5. Total Licensed Bed Capacity		95		
6. Square Footage		44,020		
7. Acquisition Cost				
a. Land		59,000		
b. Building		533,000		
<b>Part B - Owner and Related Parties</b>	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	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 9/30/17	1,050,976			
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Crossings LLC DBA Vi	2330	9/30/2017	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. <b>Total Building Interest Expense</b> (A1 - A4 + B5)	\$			

*(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 \		2330		9/30/2017		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 ( <i>Specify</i> )				\$	22,350	22,350	
A. Item		Rate	Amount				
Equipment Loan - Various		4.75%	22,350				
Lender							
Webster Bank							
Address of Lender							
P.O. Box 191 Waterbury, CT 06720-0191							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$	22,350	22,350	
12. D. Other Interest Expense ( <i>Specify</i> )				\$	1,691	1,691	
Admin interest							
13. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)				\$	24,041	24,041	
14. Insurance							
a. Insurance on Property (buildings only)				\$	14,215	14,215	
b. Insurance on Automobiles				\$	3,175	3,175	
c. Insurance other than Property (as specified above)							
1. Umbrella ( <i>Blanket Coverage</i> )				\$	10,400	10,400	
2. Fire and Extended Coverage				\$			
3. Other ( <i>Specify</i> )				\$	40,013	40,013	
General Liability							
14d. <b>Total Insurance Expenditures</b> (14a + b + c)				\$	67,803	67,803	
15. <b>Total All Expenditures</b> (A-13 thru C-14)				\$	8,499,808	8,499,808	

### 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 He				2330	9/30/2017	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.	10	12M	Salaries not related to Resident Care	\$ 8,807	8,807		
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
<b>Page 13 - Professional Fees</b>							
5.	13	8e/8	Resident Care Physicians **	\$ 794	794		
6.	13	10a	Occupational Therapy	\$ 181,577	181,577		
7.			Other - See attached Schedule	\$ 45,499	45,499		
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.	15	1e	Accounting & Legal	\$ 10,285	10,285		
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$ 871	871		
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 *	\$ 30,156	30,156		
19.	16	9j	Income Tax / Corporate Business Tax	\$ 251	251		
20.			Fund Raising / Contributions	\$			
21.	16 / 1	m12/	Unallowable Management Fees	\$ 223,247	223,247		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 143,155	143,155		
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 644,642	644,642		

\* 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)
<b>Total Other Salaries Adjustment</b>			\$ -	\$ -	\$ -

**Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B2	Dentist	\$ 7,110		
13	B3	Pharmacist	\$ 10,594		
13	8a	Medical Director (over the limit)	\$ 21,669		
13	B12	Consulting Fees Rehabilitation, Therapy and Ancillary	\$ 1,763		
13	B12	Consulting Fees Nursing	\$ 4,363		
<b>Total Other Fees Adjustments</b>			\$ 45,499	\$ -	\$ -

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
15	1a	Benefits on Salaries not Related to Resident Care	\$ 2,497		
16	L3	Gifts to Residents and Staff	\$ 3,395		
16	M13	Crime Insurance - Admin	\$ 835		
16	M13	Miscellaneous Expenses	\$ 27,980		
16	M13	Penalties - Admin	\$ 10		
16	M13	Bank Charges - Admin	\$ 19,726		
16	M8a	Chamber of Commerce Dues	\$ 280		
16	M13	Amortization of Goodwill	\$ 88,432		
<b>Total Other A&amp;G Adjustments</b>			\$ 143,155	\$ -	\$ -

**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				2330	9/30/2017	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 644,642	644,642		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5a2	Prescription Drugs	\$ 184,589	184,589		
28.	20	5d	Ambulance/Limousine	\$ 4,297	4,297		
29.	20	5f	X-rays, etc	\$ 12,510	12,510		
30.	20	5h	Laboratory	\$ 18,931	18,931		
31.	20	5c	Medical Supplies	\$ 9,622	9,622		
32.	20	5e2	Oxygen (non emergency)	\$ 10,034	10,034		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 32,417	32,417		
<b>Page 22 - Maintenance and Property</b>							
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	\$ 2,281	2,281		
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$ 13,891	13,891		
<b>Not For Profit Providers Only</b>							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51.	<b>Total Amount of Decrease (Items 1 - 50)</b>			\$ 933,214	933,214		

\*\*\* 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  
9/30/2017

**Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Equipment Rental	\$ 4,065		
20	5j	Equipment Rental - Rehabilitation, Therapy & Ancillary	\$ 14,565		
20	5a2/b/c	Procure LTC Pharmacy of CT (Disallowance of markups)	\$ 1,085		
20	5j	IV Therapy - Rehabilitation, Therapy & Ancillary	\$ 1,750		
20	5j	Flu Vaccine - Medical Services	\$ 3,240		
20	5i	Cable TV Expense - Resident Rooms	\$ 7,712		
<b>Total Other Ancillary Costs</b>			\$ 32,417	\$ -	\$ -

**Schedule of Excess Movable Equipment Depreciation**

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

**Schedule of Other Property Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Depreciation on Mattresses & TV's	\$ 2,281		
<b>Total Other Property Adjustments</b>			\$ 2,281	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30	IV8	Misc Other Income	\$ 11,893		
30	IV5	Interest Income	\$ 307		
27	12D	Other Interest	\$ 1,691		
<b>Total Other Adjustments</b>			\$ 13,891	\$ -	\$ -

Schedule of Unallowable Building Interest

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

## F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
New Milford Crossings LLC DBA Villag	2330	9/30/2017		30	37
Item	Total	CCNH	RHNS	(Specify)	
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 8,427,341	8,427,341			
b. Medicaid Room and Board Contractual Allowance **	\$ (3,278,653)	(3,278,653)			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 1,496,239	1,496,239			
b. Medicare Room and Board Contractual Allowance **	\$ 491,983	491,983			
4. a. Private-Pay Residents and Other	\$ 1,032,912	1,032,912			
b. Private-Pay Room and Board Contractual Allowance **	\$ (167,847)	(167,847)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 141,162	141,162			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (141,162)	(141,162)			
c. Prescription Drugs - Non-Medicare	\$ 19,977	19,977			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (19,859)	(19,859)			
2. a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$ 426,925	426,925			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (356,419)	(356,419)			
c. Physical Therapy - Non-Medicare	\$ 24,688	24,688			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (20,617)	(20,617)			
4. a. Speech Therapy - Medicare	\$ 64,653	64,653			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (50,316)	(50,316)			
c. Speech Therapy - Non-Medicare	\$ 2,536	2,536			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (2,061)	(2,061)			
5. a. Occupational Therapy - Medicare	\$ 344,215	344,215			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (312,672)	(312,672)			
c. Occupational Therapy - Non-Medicare	\$ 25,527	25,527			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (18,370)	(18,370)			
6. a. Other ( <i>Specify</i> ) - Medicare	\$ (274)	(274)			
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ (1)	(1)			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 8,129,907	8,129,907			
<b>IV. Other Revenue*</b>					
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> )	\$ 307	307			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 29,818	29,818			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 30,125	30,125			
<b>VI. Total All Revenue</b> (III +V)	\$ 8,160,032	8,160,032			

\* 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 II	Medicare Pt A Contra Other	\$ (42,504)		
30, Line II	Medicare Pt A Lab	\$ 12,195		
30, Line II	Medicare Pt A X-Ray	\$ 6,995		
30, Line II	Mgd Medicare IV Therapy	\$ 405		
30, Line II	Mgd Medicare Contra Other	\$ (4,547)		
30, Line II	Medicare Pt A IV Therapy	\$ 23,314		
30, Line II	Medicare Pt B Prior Period	\$ (1,530)		
30, Line II	Mgd Medicare Lab	\$ 2,537		
30, Line II	Medicare Pt A Settlement	\$ 1,256		
30, Line II	Mgd Medicare X-Ray	\$ 1,605		
<b>Total Other Resident Revenue - Medicare</b>		\$ (274)	\$ -	\$ -

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

**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
30, Line II	Medicaid Contra Other	\$ (3,408)		
30, Line II	Medicaid Lab	\$ 246		
30, Line II	Commercial Insurance Contra Other	\$ (566)		
30, Line II	Medicaid X-Ray	\$ 3,161		
30, Line II	Commercial Insurance Lab	\$ 37		
30, Line II	Commercial Insurance X-Ray	\$ 529		
<b>Total Other Resident Revenue</b>		\$ (1)	\$ -	\$ -

**Interest Income**

**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30, Line IV	Interest from M&T Savings Account		\$ 307		
<b>Total Interest Income</b>			\$ 307	\$ -	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
30, Line IV	Prior Period Other	\$ 750		
30, Line IV	United Healthcare Rebate	\$ 17,175		
30, Line IV	Refunds	\$ 8,456		
30, Line IV	Medical Records	\$ 201		
30, Line IV	National Healthcare Payback	\$ 3,236		
<b>Total Other Revenue</b>		\$ 29,818	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Crossings LLC DBA Villa	2330	9/30/2017	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	207,511
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,248,768
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	37,950
5. Prepaid Expenses			\$	142,850
a. Insurance (Property & Workers Comp)	18,131			
b. Taxes (Real Estate, Personal Property, Corp)	65,775			
c. Management	35,532			
d. Other	23,412			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	26,928
Patient Funds	23,304			
Due from Related	3,624			
<b>A-9. Total Current Assets (Lines A1 thru 8)</b>			<b>\$</b>	<b>1,664,007</b>
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>1,182,532</u>		\$	998,213
	Accum. Depreciation <u>184,319</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>305,626</u>		\$	200,392
	Accum. Depreciation <u>105,234</u>	Net		
7. Motor Vehicles	*Historical Cost <u>15,661</u>		\$	1,958
	Accum. Depreciation <u>13,703</u>	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	18,391
Construction in Progress	18,391			
<b>B-10. Total Fixed Assets (Lines B1 thru 9)</b>			<b>\$</b>	<b>1,218,954</b>

\* 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 New Milford Crossings LLC DBA Villa	License No. 2330	Report for Year Ended 9/30/2017	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	2,882,961
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			\$	
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	795,885
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> )			\$	
_____				
_____				
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$	795,885
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$	3,678,846

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



**Annual Report of Long-Term Care Facility**

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

Name of Facility New Milford Crossings LLC DBA Village Cre		License No. 2330	Report for Year Ended 9/30/2017	Page 33	of 37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	441,286
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> )				\$	202,967
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> )				\$	
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities ( <i>itemize</i> )				\$	1,018,140
Accrued Expenses		38,284	Accrued Accounting Fees	26,640	
Patient Funds		23,304	Due to Third Party	33,380	
Due to Related Party		239,143	Due to Realty	507,283	
Accrued User Fee		133,456	Accrued Worker's Comp	16,650	
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>				<b>\$</b>	<b>1,662,393</b>

\* 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 C		License No. 2330	Report for Year Ended 9/30/2017	Page 34	of 37
Account				Amount	
Total Brought Forward:				1,662,393	
<b>Liabilities (cont'd)</b>					
B. Long-Term Liabilities					
1. Loans Payable-Equipment ( <i>itemize</i> )				\$ 748,170	
Name of Lender	Purpose	Amount	Date Due		
	Equipment Loan	748,170			
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> )				\$	
_____					
_____					
_____					
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 748,170	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 2,410,563	

**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 Vill	2330	9/30/2017	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
<b>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	1,608,059
6. Gain or Loss for Period			\$	(339,776)
	10/1/2016	thru 9/30/2017		
7. Total Net Worth			\$	1,268,283
<b>C. Total Reserves and Net Worth</b>			\$	1,268,283
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	3,678,846

### H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
New Milford Crossings LLC DBA Villag	2330	9/30/2017	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2016			\$	1,602,338
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	8,160,032
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	8,499,808
D. Net Income or Deficit			\$	(339,776)
E. Balance			\$	1,262,562
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
Change in Interest Rate Swap PY			5,721	
F-3. Total Additions			\$	5,721
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. <b>Balance at End of Period</b>			\$	1,268,283
09/30/17				

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

Name of Facility New Milford Crossings LLC DBA Village	License No. 2330	Report for Year Ended 9/30/2017	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)		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Blum Shapiro & Co				
Address			Phone Number	
2 Enterprise Dr, Shelton, CT 06484			203-944-2100	