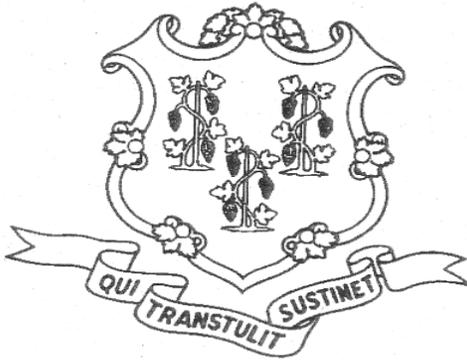


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2015

Name of Facility (as licensed) The Kent, LTD	
Address (No. & Street, City, State, Zip Code) 46 Maple Street Kent, CT 06757	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH 2147-C	RHNS	(Specify)	Medicare Provider 07-5391
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Medicaid Provider Numbers:	CCNH 21189	RHNS	ICF-IID
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For Department Use Only

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

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) The Kent, LTD	License No. 2147-C	Report for Year Ended 9/30/2015	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for The Kent, LTD [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

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

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility The Kent, LTD	Period Covered:	From 10/1/2014	To 9/30/2015	
Address of Facility 46 Maple Street Kent, CT 06757				
Report Prepared By Apple Health Care, Inc.	Phone Number (860) 678-9755	Date		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility (860)927-5368		Report for Year Ended 9/30/2015	Page 2	of 37
Name of Facility (as shown on license) The Kent, LTD		Address (No. & Street, City, State, Zip) 46 Maple Street Kent, CT 06757		
License Numbers:	CCNH 2147-C	RHNS	(Specify)	Medicare Provider No. 07-5391
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 type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Linda Urbanski		Nursing Home Administrator's License No.:	0001170	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

**General Information and Questionnaire
 Corporate Owners**

Name of Facility The Kent, LTD	License No. 2147-C	Report for Year Ended 9/30/2015	Page 3A	of 37
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If this facility is owned or operated as a corporation, provide the following information:

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

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

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

**General Information and Questionnaire
 Related Parties***

Name of Facility The Kent, LTD	License No. 2147-C	Report for Year Ended 9/30/2015	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Brian J. Foley	21 Waterville Road Avon, CT	<input type="radio"/>	<input checked="" type="radio"/>		Real Estate Rental	Pg. 22 Line 9	780,000	780,000
Apple Health Care	21 Waterville Road Avon, CT	<input type="radio"/>	<input checked="" type="radio"/>		Management & Accounting Services	Pg. 16 Line m12	344,733	344,733
Healthport Services	21 Waterville Road Avon, CT	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10/13	108,274	108,274
Allstar	21 Waterville Road Avon, CT	<input checked="" type="radio"/>	<input type="radio"/>	15%	Therapy Services	Pg. 13 B5/B9/B10	274,913	252,095
Corporate Employee	21 Waterville Road Avon, CT	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	10,195	10,195
Employees @ various Apple Facilities		<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	126,458	126,458
Apple Health Care	21 Waterville Road Avon, CT	<input type="radio"/>	<input checked="" type="radio"/>		Pension Plan (401K)	Pg. 15 1a7	6,135	6,135
Aetna	PO Box 88860 Chicago, IL	<input checked="" type="radio"/>	<input type="radio"/>		Group Medical	Pg. 15 1a5	453,276	
Delta Dental	PO Box 23700 Newark, NJ	<input checked="" type="radio"/>	<input type="radio"/>		Group Dental	Pg. 15 1a5	29,979	

* Use additional sheets if necessary.

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

Annual Report of Long-Term Care Facility

**General Information and Questionnaire
Related Parties***

Name of Facility The Kent, LTD	License No. 2147-C	Report for Year Ended 9/30/2015	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Unum Life Insurance	PO Box 406946 Atlanta, GA	X			Group Life & Disability	Pg. 15 1a6	8,719	
Marsh	PO Box 19636 Newark, NJ	X			Property, Liability, & Umbrella Insurance	Pg. 27 14a	79,890	
Medstat	41 Northwest Dr. Plainville, CT	X		9%	Pharmacy	Pg. 13B3/Pg. 20 5a	186,524	179,064
AIG	PO Box 10472 Newark, NJ	X			Worker's Compensation	Pg. 15 1a1	103,016	
Brendan Foley	21 Waterville Rd. Avon, CT	X				##		
Ryan Vess	21 Waterville Rd. Avon, CT		X			##		

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

**Kent
Shared Employees
Provider 1068-C
Cost Report 2015**

41001- Salaries Administrator

Source	Facility	Employee	Amount	Hours
Corporate		Wagner	84,451.15	1,462.75
Corporate		Urbanski	29,615.46	560.00
			114,066.61	2,022.75

41002- Salaries Clerical

Source	Facility	Employee	Amount	Hours
4/30/2015	Healthport	Alderman	387.50	15.50
			387.50	15.50

41003- Salaries Accounting

Source	Facility	Employee	Amount	Hours
Payroll	corporate		2,026.00	65.00
Billing	corporate		8,169.00	424.00
			10,195.00	489.00

41004- Salaries Social Service

Source	Facility	Employee	Amount	Hours
10/31/2014	Wolcott Hall	A. Hazzard	1,312.50	39.00
11/30/2014	Wolcott Hall	A. Hazzard	250.00	7.00
12/31/2014	Wolcott Hall	A. Hazzard	337.50	13.50
1/31/2015	Wolcott Hall	A. Hazzard	525.00	21.00
			2,425.00	80.50

41006- Salaries Maintenance

Source	Facility	Employee	Amount	Hours
11/30/2014	Healthport	Carrigan	4,193.26	139.75
2/28/2015	Healthport	Carrigan	3,618.75	144.75
4/30/2015	Healthport	Carrigan	4,571.88	183.00
5/31/2015	Healthport	Carrigan	3,800.00	152.00
6/30/2015	Healthport	Carrigan	3,750.00	150.00
7/31/2015	Healthport	Carrigan	4,800.00	192.00
8/31/2015	Healthport	Carrigan	2,975.00	119.00
9/30/2015	Healthport	Carrigan	3,800.00	152.00
			31,508.89	1,232.50

41008 - Salaries Staff Development

Source	Facility	Employee	Amount	Hours
11/30/2014	Wolcott Hall	Neri	218.75	8.75
			218.75	8.75

45001 - Salaries RN

Source	Facility	Employee	Amount	Hours
10/31/2014	Plainville	Smikle-Russell	560.00	16.00
11/30/2014	Wolcott	Neri	156.25	6.25
11/30/2014	Wolcott	Neri	356.25	14.25
12/31/2014	Wolcott	Neri	200.00	8.00
4/30/2015	Healthport	Basset	14.50	0.75
4/30/2015	Healthport		365.25	25.50
			1,652.25	70.75

45002 - Salaries - LPN

Source	Facility	Employee	Amount	Hours
12/31/2014	Brightview	Pace	(178.50)	(8.50)
2/28/2015	Wolcott Hall	Ross	(323.00)	(17.00)
3/31/2015	Wolcott Hall	Ross	(504.38)	(24.50)
4/30/2015	Healthport	Gayle-Smith	52.00	1.25
4/30/2015	Healthport	Parker	248.00	8.00
5/31/2015	Healthport	Parker	47.50	1.00
6/30/2015	Healthport	Pierre	360.38	8.00
			(298.00)	(31.75)

45003 - Salaries - CNA

Source	Facility	Employee	Amount	Hours
10/31/2014	Plainville	Hoffman	(391.57)	(44.75)
10/31/2014	Plainville	Zoccano	(391.57)	(44.75)
11/30/2014	Plainville	Hoffman	(456.63)	(51.50)
11/30/2014	Plainville	Zoccano	(456.63)	(51.50)
12/31/2014	Plainville	Williams	(271.06)	(30.25)
12/31/2014	Plainville	Stephenson	(271.06)	(30.25)
1/31/2015	Coccoma	Ghazal	146.72	8.00
3/31/2015	Wolcott Hall	Acosta	106.00	8.00
3/31/2015	Wolcott Hall	Peterson	99.76	8.00
2/28/2015	Wolcott Hall	Maestri	117.12	8.00
2/28/2015	Wolcott Hall	Martin	100.73	8.25
2/28/2015	Wolcott Hall	Peterson	99.76	8.00
			(1,568.43)	(204.75)

45010- Salaries Infection Control

Source	Facility	Employee	Amount	Hours
10/31/2014	Wolcott Hall	Neri	200.00	8.00
11/30/2014	Wolcott Hall	Neri	475.00	19.00
			675.00	27.00

45017- Salaries MDS Coordinator

Source	Facility	Employee	Amount	Hours
10/31/2014	Brightview	Jennifer Heller	479.25	17.75
10/31/2014	Wolcott	Maureen Jedd	662.64	22.00
10/31/2014	Rose Haven	Duggan-Yoelson	663.00	19.50
11/30/2014	Brightview	Jennifer Heller	175.50	6.50
11/30/2014	Wolcott	Maureen Jedd	843.36	28.00
11/30/2014	Rose Haven	Duggan-Yoelson	867.00	25.50
12/31/2014	Wolcott	Maureen Jedd	745.47	24.75
12/31/2014	Rose Haven	Duggan-Yoelson	816.00	24.00
1/31/2015	Rose Haven	Duggan-Yoelson	493.00	14.50
1/31/2015	Wolcott	Maureen Jedd	203.31	6.75
3/31/2015	Rose Haven	Leonetty	224.00	8.00
			6,172.53	197.25

50001- Salaries Dietician

Source	Facility	Employee	Amount	Hours
10/31/2014	Waterbury	Hagberg	183.63	6.50
10/31/2014	Rose Haven	Leonetti	784.00	28.00
11/30/2014	Rose Haven	Leonetti	966.00	34.50
12/31/2014	Rose Haven	Leonetti	462.00	16.50
1/28/2015	Rose Haven	Leonetti	896.00	32.00
2/28/2015	Rose Haven	Leonetti	910.00	32.50
			4,201.63	150.00

50002- Salaries Chefs, Cooks

Source	Facility	Employee	Amount	Hours
11/30/2014	Healthport	Mullen	240.00	9.00
12/31/2014	Healthport	Mullen	210.00	8.75
			450.00	17.75

Total Shared	126,457.71	2,276.00
Total Shared Cor	10,195.00	489.00
Total Shared HP	33,434.02	1,310.25

Total Shared Employee **170,086.73** **4,075.25**

Kent - Healthport Services

45022- Purch Service RN - HPS

Source	Facility	Employee	Amount	Hours
10/31/2014	Healthport	Wortman	4,079.75	98.00
10/31/2014	Healthport	Carrigan	688.00	32.00
11/30/2014	Healthport	Scanzillo	711.00	17.00
11/30/2014	Healthport	Wortman	896.25	21.75
12/31/2014	Healthport	Scanzillo	2,555.24	63.00
12/31/2014	Healthport	Wortman	375.00	9.00
1/31/2015	Healthport	Scanzillo	1,451.75	31.25
1/31/2015	Healthport	Schilder	375.00	9.00
2/28/2015	Healthport	Scanzillo	1,665.75	40.25
2/28/2015	Healthport	Wortman	1,519.50	36.50
3/31/2015	Healthport	Scanzillo	384.75	9.25
3/31/2015	Healthport	Wortman	355.50	8.50
	Indirect Allocation		9,302.16	-
			24,359.65	375.50

45023- Purch Service LPN - HPS

Source	Facility	Employee	Amount	Hours
10/31/2014	Healthport	Setaro	297.00	9.00
10/31/2014	Healthport	Pierre	1,216.75	39.25
10/31/2014	Healthport	Sewell	331.50	8.50
10/31/2014	Healthport	Alicea	286.75	9.25
11/30/2014	Healthport	Setaro	317.75	10.25
11/30/2014	Healthport	arshad	552.75	17.25
11/30/2014	Healthport	pierre	442.75	14.75
12/31/2014	Healthport	Green	790.13	12.25
12/31/2014	Healthport	Parker	255.75	7.75
12/31/2014	Healthport	Gayle-Smith	600.00	20.00
12/31/2014	Healthport	pierre	668.50	22.50
12/31/2014	Healthport	Sewell	229.50	8.50
12/31/2014	Healthport	Dulford	277.50	9.25
1/31/2015	Healthport	Parker	769.50	20.25
1/31/2015	Healthport	Gayle-Smith	1,680.00	56.00
1/31/2015	Healthport	Pierre	681.50	23.50
1/31/2015	Healthport	Dulford	247.50	8.25
2/28/2015	Healthport	Parker	1,204.50	36.50
2/28/2015	Healthport	Gayle-Smith	270.00	9.00
2/28/2015	Healthport	Pierre	1,472.50	48.00
	Indirect Allocation		9,037.35	
			21,629.48	390.00
Total Healthpor			45,989.13	765.50

Apple Shared Employee Report

Reporting Period: From 3/8/2015 to 9/19/2015

Emp Num	LastName	FirstName	HomeFcltyCode	Home Facility	WorkedCode
29000067	Herrick	JULIE	11	Wolcott Hall	23
29000067	Herrick	JULIE	11	Wolcott Hall	23
29000067	Herrick	MAUREEN	11	Wolcott Hall	23
29000067	Herrick	MAUREEN	11	Wolcott Hall	23
29000067	Herrick	MAUREEN	11	Wolcott Hall	23
29000067	Herrick	MAUREEN	11	Wolcott Hall	23
29970331	Iworisha	KELI	29	Healthport Srvc	23
29000067	Herrick	ADELINE	11	Wolcott Hall	23
29000067	Herrick	ADELINE	11	Wolcott Hall	23
29000067	Herrick	ADELINE	11	Wolcott Hall	23
29970331	Iworisha	GORDON	29	Healthport Srvc	23
29970702	Jones	Sharon	29	Healthport Srvc	23
29970702	Jones	Sharon	29	Healthport Srvc	23
29970702	Jones	June	29	Healthport Srvc	23
29970702	Jones	Sharon	29	Healthport Srvc	23
29970702	Jones	June	29	Healthport Srvc	23
29970702	Jones	Maureen	29	Healthport Srvc	23
29970702	Jones	Sharon	29	Healthport Srvc	23
29970331	Iworisha	Elaine	29	Healthport Srvc	23
29970702	Jones	June	29	Healthport Srvc	23
29970702	Jones	Maureen	29	Healthport Srvc	23
29970702	Jones	Sharon	29	Healthport Srvc	23
29970331	Iworisha	NIGEL	15	Gardner Height	23
29970331	Iworisha	Elaine	29	Healthport Srvc	23
29970702	Jones	June	29	Healthport Srvc	23
29970702	Jones	Sharon	29	Healthport Srvc	23
29970331	Iworisha	Elaine	29	Healthport Srvc	23
29970702	Jones	June	29	Healthport Srvc	23
29970702	Jones	Sharon	29	Healthport Srvc	23
29970331	Iworisha	NIGEL	15	Gardner Height	23
29970331	Iworisha	Elaine	29	Healthport Srvc	23
29970702	Jones	June	29	Healthport Srvc	23
29970331	Iworisha	NIGEL	15	Gardner Height	23
29970702	Jones	June	29	Healthport Srvc	23

29970702 Jones	June	29 Healthport Srvc	23
29970702 Jones	June	29 Healthport Srvc	23
23970760 Caldwell	Nancy	23 Kent	1
23970760 Caldwell	Nancy	23 Kent	1
29970702 Jones	June	29 Healthport Srvc	23
29970702 Jones	Sharon	29 Healthport Srvc	23
29970702 Jones	Andy	29 Healthport Srvc	23
29970702 Jones	Andy	29 Healthport Srvc	23
29970702 Jones	Andy	29 Healthport Srvc	23
29970702 Jones	Crystal	29 Healthport Srvc	23
29970331 Iworisha	Mohamed	29 Healthport Srvc	23
29970331 Iworisha	Laverne	29 Healthport Srvc	23
29970331 Iworisha	Charmayne	29 Healthport Srvc	23
29970331 Iworisha	Charmayne	29 Healthport Srvc	23
29970331 Iworisha	Laverne	29 Healthport Srvc	23
29970702 Jones	Andy	29 Healthport Srvc	23
29970331 Iworisha	Charmayne	29 Healthport Srvc	23
29970702 Jones	Jillian	29 Healthport Srvc	23
29970331 Iworisha	Laverne	29 Healthport Srvc	23
29970702 Jones	Jillian	29 Healthport Srvc	23
29970331 Iworisha	Charmayne	29 Healthport Srvc	23
29970702 Jones	Andy	29 Healthport Srvc	23
29970702 Jones	Jillian	29 Healthport Srvc	23
29970331 Iworisha	Mohamed	29 Healthport Srvc	23
29970331 Iworisha	Laverne	29 Healthport Srvc	23
29970331 Iworisha	Charmayne	29 Healthport Srvc	23
29970702 Jones	Andy	29 Healthport Srvc	23
29970702 Jones	Jillian	29 Healthport Srvc	23
29970331 Iworisha	Laverne	29 Healthport Srvc	23
29970331 Iworisha	Charmayne	29 Healthport Srvc	23
29970702 Jones	KerryAnn	29 Healthport Srvc	23
29970702 Jones	Jillian	29 Healthport Srvc	23
29970702 Jones	Andy	29 Healthport Srvc	23
29970702 Jones	Andy	29 Healthport Srvc	23
29970331 Iworisha	Charmayne	29 Healthport Srvc	23
29970702 Jones	Andy	29 Healthport Srvc	23
29970331 Iworisha	Marcia	29 Healthport Srvc	23
29970702 Jones	Andy	29 Healthport Srvc	23
29970702 Jones	Jillian	29 Healthport Srvc	23
29970702 Jones	Charmayne	29 Healthport Srvc	23
29970702 Jones	Charmayne	29 Healthport Srvc	23
29970702 Jones	Andy	29 Healthport Srvc	23
29970702 Jones	Jillian	29 Healthport Srvc	23

29000067 Herrick	MAUREEN	11 Wolcott Hall	23
29000067 Herrick	MAUREEN	11 Wolcott Hall	23
29000067 Herrick	MAUREEN	11 Wolcott Hall	23
29000067 Herrick	MAUREEN	11 Wolcott Hall	23
29000067 Herrick	MAUREEN	11 Wolcott Hall	23
29000067 Herrick	MAUREEN	11 Wolcott Hall	23
29000067 Herrick	MAUREEN	11 Wolcott Hall	23
29000067 Herrick	MAUREEN	11 Wolcott Hall	23
29000067 Herrick	MAUREEN	11 Wolcott Hall	23
29000067 Herrick	MAUREEN	11 Wolcott Hall	23
29000067 Herrick	MAUREEN	11 Wolcott Hall	23
29000067 Herrick	MAUREEN	11 Wolcott Hall	23
29000067 Herrick	MAUREEN	11 Wolcott Hall	23
29970331 Iworisha	KATHLEE	12 Hewitt	23
29970331 Iworisha	KATHLEE	12 Hewitt	23
29970331 Iworisha	KATHLEE	12 Hewitt	23
29000067 Herrick	MARY	2 Rose Haven	23
29000067 Herrick	MARY	2 Rose Haven	23

Kent	923-45017	Salaries - MDS Coordinator - JobTitle = MDS COORDINATOR
Kent	923-45017	Salaries - MDS Coordinator - JobTitle = MDS COORDINATOR
Kent	923-45017	Salaries - MDS Coordinator - JobTitle = MDS COORDINATOR
Kent	923-45017	Salaries - MDS Coordinator - JobTitle = MDS COORDINATOR
Kent	923-45017	Salaries - MDS Coordinator - JobTitle = MDS COORDINATOR
Kent	923-45017	Salaries - MDS Coordinator - JobTitle = MDS COORDINATOR
Kent	923-45017	Salaries - MDS Coordinator - JobTitle = MDS COORDINATOR
Kent	923-45017	Salaries - MDS Coordinator - JobTitle = MDS COORDINATOR
Kent	923-45017	Salaries - MDS Coordinator - JobTitle = MDS COORDINATOR
Kent	923-45017	Salaries - MDS Coordinator - JobTitle = MDS COORDINATOR
Kent	923-45017	Salaries - MDS Coordinator - JobTitle = MDS COORDINATOR
Kent	923-45017	Salaries - MDS Coordinator - JobTitle = MDS COORDINATOR
Kent	923-45017	Salaries - MDS Coordinator - JobTitle = MDS COORDINATOR
Kent	923-45017	Salaries - MDS Coordinator - JobTitle = MDS COORDINATOR

Kent	923-50001	Salaries - Dietitians - JobTitle = REGIONAL DIETICIAN
Kent	923-50001	Salaries - Dietitians - JobTitle = REGIONAL DIETICIAN

Grand Total

PayDate	Hours	Dollars
#####	-	200.00
5/7/2015	-	200.00
#####	7.50	225.90
#####	6.75	203.31
4/2/2015	9.00	271.08
#####	9.00	271.08
#####	-	133.97
	<u>32.25</u>	<u>1,505.34</u>
#####	7.50	187.50
#####	4.50	112.50
#####	4.50	112.50
	<u>16.50</u>	<u>412.50</u>
9/3/2015	24.00	600.00
	<u>24.00</u>	<u>600.00</u>
#####	51.00	730.50
#####	50.50	720.75
4/2/2015	53.00	726.00
4/2/2015	46.25	658.50
4/9/2015	26.00	375.00
4/9/2015	16.75	347.75
4/9/2015	49.00	691.50
#####	72.00	968.00
#####	26.00	375.00
#####	25.50	365.25
#####	26.50	384.75
#####	69.00	767.63
#####	37.00	555.00
#####	26.00	375.00
#####	24.50	345.75
#####	86.25	1,184.33
#####	25.50	365.25
#####	27.50	404.25
5/7/2015	75.50	960.49
5/7/2015	68.75	850.50
5/7/2015	25.50	365.25
#####	43.25	404.64
#####	26.00	375.00

#####	26.00	375.00
6/4/2015	25.50	513.25
#####	8.25	(297.00)
#####	8.75	(315.00)
8/6/2015	25.50	365.25
8/6/2015	26.00	375.00
	<u>1,097.25</u>	<u>14,312.59</u>

#####	8.50	246.50
#####	16.50	255.75
4/2/2015	47.50	736.25
4/2/2015	17.50	262.50
4/9/2015	14.50	224.75
#####	15.00	225.00
#####	36.25	630.75
5/7/2015	35.50	585.75
#####	16.50	247.50
#####	32.00	496.00
#####	47.00	775.50
#####	14.25	356.25
#####	9.25	259.00
#####	16.50	222.75
6/4/2015	16.50	272.25
6/4/2015	8.00	80.00
6/4/2015	48.50	654.75
#####	18.50	286.75
#####	16.50	247.50
#####	51.50	849.75
#####	17.00	263.50
#####	16.50	222.75
#####	17.00	255.00
#####	17.50	288.75
#####	16.50	239.25
#####	17.00	229.50
#####	15.00	232.50
7/2/2015	31.00	480.50
7/9/2015	33.50	552.75
#####	14.50	224.75
8/6/2015	17.00	272.00
8/6/2015	15.50	240.25
8/6/2015	16.00	232.00
9/3/2015	17.00	280.50
#####	48.50	800.25
#####	13.50	209.25
#####	16.50	239.25

#####	32.00	652.00
#####	37.50	805.25
#####	16.50	272.25
#####	12.00	186.00
#####	16.00	232.00
	<u>939.75</u>	<u>15,325.50</u>

#####	(32.00)	(228.00)
#####	36.00	328.45
#####	29.00	269.75
#####	28.00	200.47
6/4/2015	20.25	136.69
#####	29.00	269.75
#####	28.00	200.47
7/2/2015	21.00	141.75
7/9/2015	42.00	283.50
#####	21.00	141.75
#####	21.00	141.75
#####	21.00	141.75
8/6/2015	21.00	141.75
#####	21.00	141.75
#####	21.00	141.75
#####	8.25	71.89
#####	9.25	73.75
#####	60.50	395.82
#####	43.00	291.12
#####	24.50	134.92
#####	46.75	348.38
6/4/2015	8.00	97.68
#####	20.25	139.11
#####	24.00	131.68
#####	5.25	18.38
9/3/2015	21.75	117.85
#####	-	28.00
	<u>598.75</u>	<u>4,301.91</u>

#####	7.75	263.50
#####	1.00	34.00
5/7/2015	15.00	510.00
#####	1.00	34.00
#####	1.00	34.00
#####	1.00	34.00
7/9/2015	1.00	34.00
#####	1.00	34.00

#####	8.50	256.02
#####	8.25	248.49
#####	8.50	256.02
7/9/2015	9.50	286.14
#####	7.75	233.43
#####	8.75	263.55
8/6/2015	8.75	263.55
#####	8.00	240.96
#####	8.75	263.55
#####	8.50	256.02
9/3/2015	9.50	286.14
#####	1.50	45.18
#####	8.00	260.72
#####	8.00	260.72
#####	7.50	244.43
	<u>148.50</u>	<u>4,642.42</u>

#####	8.00	224.00
#####	8.00	224.00
	<u>16.00</u>	<u>448.00</u>

2,873.00 #####

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility The Kent, LTD	License No. 2147-C	Report for Year Ended 9/30/2015	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.
 The costs incurred by Apple Health Care, inc. (a related party), to provide Accounting and Managerial services to each facility owned by Brian J. Foley, are allocated on a per bed basis.

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

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

N/A

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 The Kent, LTD			License No. 2147-C			Report for Year Ended 9/30/2015		Page 6	of 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							
	<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"/>							
	<input type="radio"/>	<input type="radio"/>							
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input checked="" type="radio"/> Yes <input type="radio"/> No	Total ***	

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

General Information and Questionnaire
Accounting Basis

Name of Facility The Kent, LTD	License No. 2147-C	Report for Year Ended 9/30/2015	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:
 Accrual Cash Modified Cash

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

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

1 Preparation of audited financials (dissallow Pg. 28)	\$ 4,380
2 Preparation of tax returns	\$ 2,002
3	\$
4	\$
	Charge for Services Provided
	\$ 6,383

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

Legal Services Information

Name of Legal Firm or Independent Attorney 1 Clerk of the Superior Court 2 Law Offices of Jason G. DeGenaro 3 Summa & Ryan 4 5	Telephone Number (203) 453-4101
---	------------------------------------

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

1
2 23 Water St. Guilford, CT 06437
3 228 Meadow St. Waterbury, CT 06710
4
5

Services Provided by This Firm (*describe fully*)

1 Probate	\$ 93
2 Collections	\$ 4,070
3 Legal Advice - Closing Facility	\$ 11,183
4	\$
5	\$
	Charge for Services Provided
	\$ 15,346

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

Schedule of Resident Statistics

Name of Facility The Kent, LTD			License No. 2147-C		Report for Year Ended 9/30/2015				Page 8	of 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	90	90			90	90			90	90			
B. On last day of THIS report period	90	90			90	90			90	90			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	52	52			52	52			52	52			
B. As of midnight of THIS report period	19	19			19	19			19	19			
3. Total Number of Days Care Provided During Period													
A. Medicare	2,467	2,467			2,104	2,104			363	363			
B. Medicaid (Conn.)	12,820	12,820			9,968	9,968			2,852	2,852			
C. Medicaid (other states)	1,693	1,693			1,455	1,455			238	238			
D. Private Pay	2,956	2,956			2,375	2,375			581	581			
E. State SSI for RCH													
F. Other (Specify)													
G. Total Care Days During Period (3A thru F)	19,936	19,936			15,902	15,902			4,034	4,034			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days													
B. Other Bed Reserve Days													
5. Total Resident Days (3G + 4A + 4B)	19,936	19,936			15,902	15,902			4,034	4,034			

Schedule of Resident Statistics (Cont'd)

Name of Facility The Kent, LTD			License No. 2147-C			Report for Year Ended 9/30/2015			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days									CCNH	RHNS	(Specify)		
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	1	15			3								
Per Diem Rate													
a. One bed rm.			256.47		375.00								
b. Two bed rms.	Various		238.84		350.00								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									606	606			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									5,124	5,124			
D. Total Physical Therapy Treatments									5,730	5,730			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									397	397			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									526	526			
D. Total Speech Therapy Treatments									923	923			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									769	769			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									4,248	4,248			
D. Total Occupational Therapy Treatments									5,017	5,017			

Report of Expenditures - Salaries & Wages

Name of Facility The Kent, LTD	License No. 2147-C	Report for Year Ended 9/30/2015	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	120,760	2,139				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	45,449	2,888				
5. Dietary Service						
a. Head Dietitian	4,650	166				
b. Food Service Supervisor	42,147	2,119				
c. Dietary Workers	224,883	17,928				
6. Housekeeping Service						
a. Head Housekeeper	37,882	1,642				
b. Other Housekeeping Workers	125,531	11,568				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	107,717	4,854				
8. Laundry Service						
a. Supervisor	10,215	458				
b. Other Laundry Workers	43,275	4,194				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants	106,551	4,833				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	111,720	2,294				
b. RN						
1. Direct Care	514,015	15,374				
2. Administrative**	80,691	2,370				
c. LPN						
1. Direct Care	359,822	15,325				
2. Administrative**						
d. Aides and Attendants	756,110	51,454				
e. Physical Therapists	2,108	128				
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	75,697	4,068				
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	94,590	3,787				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	2,863,812	147,590				

* 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
The Kent, LTD				2147-C	9/30/2015				11	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended				Page	of
The Kent, LTD				2147-C	9/30/2015				12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Krista Wagner	81,699				Administrator 10/1/14 - 6/6/15	1,401				
Linda Urbanski	39,061				Administrator 6/7/15 - 9/30/15	739		Shelton Lakes/Harbor View	44926/181	1120 / 360
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
The Kent, LTD	2147-C	9/30/2015	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	8,242	87				
3. Pharmacist	5,938	40				
4. Podiatrist	185	5				
5. Physical Therapy						
a. Resident Care	114,735	1,433				
b. Other						
6. Social Worker	5,680	53				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	36,000					
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify) Eye/Ear Dr. (Healthdrive)	711	9				
9. Speech Therapist						
a. Resident Care	43,870	231				
b. Other						
10. Occupational Therapist						
a. Resident Care	94,098	1,254				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	32,984	520				
2. Administrative***						
b. LPN						
1. Direct Care	26,956	507				
2. Administrative***						
c. Aides	81,234	2,531				
d. Other						
12. Other (Specify) See Attached Schedule	10,450	57				
B-13 Total Fees Paid in Lieu of Salaries	461,082	6,725				

* 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.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
The Kent, LTD	2147-C	9/30/2015	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 103,016	103,016		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 92,801	92,801		
4. Social Security (F.I.C.A.)	\$ 193,197	193,197		
5. Health Insurance	\$ 353,841	353,841		
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 8,719	8,719		
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 6,135	6,135		
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*	\$ 569,202	569,202		
d. Accounting and Auditing	\$ 6,383	6,383		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 15,346	15,346		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 17,648	17,648		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 40,722	40,722		
2. Cellular Phones	\$			
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$			
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$			
2. Other (<i>Specify</i>) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 348,407	348,407		
Subtotal	\$ 1,755,417	1,755,417		

* 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 The Kent, LTD	License No. 2147-C	Report for Year Ended 9/30/2015	Page 16	of 37
Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,755,417	1,755,417	
1. Travel and Entertainment				
1. Resident Travel and Entertainment	\$ 40,128	40,128		
2. Holiday Parties for Staff	\$ 3,459	3,459		
3. Gifts to Staff and Residents	\$ 15,377	15,377		
4. Employee Travel	\$ 10,702	10,702		
5. Education Expenses Related to Seminars and Conventions	\$ 379	379		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$			
7. Other (<i>Specify</i>) See Attached Schedule	\$			
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 8,640	8,640		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$			
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 8,462	8,462		
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	\$ 2,471	2,471		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 6,492	6,492		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 125	125		
9. Subscriptions	\$ 1,257	1,257		
10. Contributions*** See Attached Schedule	\$ 1,415	1,415		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$			
12. Administrative Management Services**	\$ 344,733	344,733		
13. Other (<i>Specify</i>) See Attached Schedule	\$ 72,785	72,785		
C-14 Total Administrative & General Expenditures	\$ 2,271,842	2,271,842		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Advertising - Public Relations	\$ 8,462		
Total Other Advertising	\$ 8,462	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Russell Phillips & Assoc (LTC-MAP)	\$ 350		
CAHCF	\$ 6,142		
Total Dues	\$ 6,492	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Kent Chamber of Commerce - Golf Donation	\$ 500		
Kent/Warren Volunteer Fire Department	\$ 765		
Uconn Foundation	\$ 150		
Total Contributions	\$ 1,415	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Corporate Fees - Non Reimbursable	\$ 26,878		
Licenses & Fees	\$ 9,705		
Pre Employment Screening	\$ 11,691		
Point Click Care Fees	\$ 6,705		
Bank Charges	\$ -		
Resident Expenses	\$ -		
Account Write Off	\$ 17,806		
Total Other Administrative and General	\$ 72,785	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility The Kent, LTD	License No. 2147-C	Report for Year Ended 9/30/2015	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Apple Health Care, Inc.	344,733	Accounting & Managerial Services	Pg. 16 m12

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

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

Name of Facility The Kent, LTD	License No. 2147-C	Report for Year Ended 9/30/2015	Page 18	of 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 137,536	137,536		
2. Non-Food Supplies	\$ 25,835	25,835		
3. Other (Specify) _____	\$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 12,119	12,119		
c. Management Services**	\$			
d. Other (Specify) _____	\$			
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 175,490	175,490		
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*	164	164		
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
The Kent, LTD	2147-C	9/30/2015	19	37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	8,218	8,218	
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. \$	5,246	5,246	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$			
c. Management Services**	\$			
d. Other (Specify)	\$			
3E. Total Laundry Expenditures (3a + b + c + d)	\$	13,464	13,464	
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	
The Kent, LTD	2147-C	9/30/2015	20	37	
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care					
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	24,279	24,279		
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. \$	44,104	44,104		
c. Management Services*		\$			
d. Other (<i>Specify</i>)		\$			
4E. Total Housekeeping Expenditures (4a + b + c + d)		\$ 68,383	68,383		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Medstat	\$	155,675	155,675		
b. Medicine Cabinet Drugs	\$				
c. Medical and Therapeutic Supplies	\$	128,817	128,817		
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	16,221	16,221		
f. X-rays and Related Radiological Procedures***	\$	33,605	33,605		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	1,182	1,182		
i. Recreation	\$	36,256	36,256		
j. Other (Specify)**** See Attached Schedule	\$	16,195	16,195		
5K. Total Resident Care Expenditures (5a - 5j)		\$ 387,951	387,951		

* 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.

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

Name of Facility The Kent, LTD			License No. 2147-C		Report for Year Ended 9/30/2015				Page of 21 37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Dubray's Outdoor Care	75 South Main St. Kent, CT 06757	<input type="radio"/>	<input checked="" type="radio"/>		Landscaping & Snow Removal	35,414			22	6a
West State Mechanical	PO Box 1045 Torrington, CT 06790	<input type="radio"/>	<input checked="" type="radio"/>		HVAC	23,714			22	6a
CWPM, LLC	PO Box 415 Plainville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>		Refuse Removal	21,836			22	6f
Preston Cahoon		<input type="radio"/>	<input checked="" type="radio"/>		Housekeeping Services	47,124			20	4b
		<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 The Kent, LTD	License No. 2147-C	Report for Year Ended 9/30/2015			Page 22	of 37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 192,046	192,046				
b. Heat	\$ 84,256	84,256				
c. Light & Power	\$ 78,366	78,366				
d. Water	\$ 53,983	53,983				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$					
f. Other (<i>itemize</i>)	\$ 24,752	24,752				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 433,403	433,403				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$ 650	650				
d. Movable Equipment	\$ 20,633	20,633				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 21,283	21,283				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 28,601	28,601				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 28,601	28,601				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 780,000	780,000				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 60,124	60,124				
c. Personal property taxes	\$ 3,269	3,269				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 893,277	893,277				

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
7/12/2013	ECG Interpretive	\$ 2,609	7	\$ 373
7/12/2013	Monitor, cables, & connectors	\$ 497	5	\$ 89
12/14/2014	Mattress Aire	\$ 5,830	5	\$ 1,469
3/12/2015	Infrastructure Configuration (JKS)	\$ 1,404	5	\$ 98
3/19/2015	Generator Project	\$ 41,861	5	\$ 2,837
3/19/2015	Payroll System Upgrade	\$ 2,429	10	\$ 83
3/24/2015	Food Processor	\$ 2,146	10	\$ 73
9/2/2015	Drain Cleaning Equipment	\$ 1,286	5	\$ 31
Total additions for Movable Equipment		\$ 58,061		\$ 5,051 *
Deletions:				
9/30/2015	Mita Copier (Northeast)	\$ (7,452)		
9/30/2015	Copier (Advanced Copy)	\$ (1,193)		
9/30/2015	2 Kyocera Mita Copiers (Advanced Copy)	\$ (6,042)		
9/30/2015	Photocopier (Advanced Copy)	\$ (6,678)		
Total deletions for Movable Equipment		\$ (21,364)		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/13/2014	Replace Valve & Bearing	\$ 4,953	10	\$ 619
11/18/2014	Gypsum Ceiling	\$ 1,599	10	\$ 200
3/17/2015	Wood Flooring	\$ 4,328	10	\$ 148
3/17/2015	Circuit Breaker	\$ 1,007	10	\$ 34
4/15/2015	Flooring - Dementia Unit	\$ 10,369	10	\$ 346
7/15/2015	Replaced 2 Hot Water Storage Tanks	\$ 21,038	20	\$ 242
9/16/2015	Installation of Heat Pump	\$ 7,379	10	\$ 53
9/22/2015	Install A/C Compressor	\$ 3,795	15	\$ 12
Total additions for Leasehold Improvement		\$ 54,466		\$ 1,653 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility

CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility The Kent, LTD			License No. 2147-C		Report for Year Ended 9/30/2015			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period	Var	Var		661,688	529,948	A		26,948	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	Var	Var		54,466		A		1,653	
C-4. Subtotal									28,601
D. Total Amortization									28,601

* 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 The Kent, LTD	License No. 2147-C	Report for Year Ended 9/30/2015	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description		Total		
1. Date Land Purchased				
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity		90		
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building				
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed		See Attached		
f. Principal balance outstanding as of _____				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
Part C - Arms-Length Leases for Real Property Improvements Only				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

CT Medicaid Cost Report Attachment Page 25

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

Note: The following facilities are collateralized by this mortgage.

Connecticut Facilities

Brightview Nursing & Retirement Center, Ltd.

Rose Haven, Ltd.

Mary Elizabeth Nursing Center, Inc.

Fowler Nursing Center, Inc.

Waterbury Extended Care Facility, Inc.

Harbor View Nursing Center, Inc.

Liberty Hall Nursing Center

Orchard Grove Specialty Care

Wolcott Hall Nursing Center, Inc.

Hewitt Health and Rehabilitation Center, Inc.

Watrous Nursing Center

Elm Hill Nursing Center, Inc.

Gardner Heights Health Care Center, Inc.

Shelton lakes Health Care Center, Inc.

Highview Health Care Center, Inc.

Westfield Manor Health Care Center, Inc.

TA Coccomo Memorial

Plainville Health Care Center, Inc.

Ledgecrest Health Care Center, Inc.

Ridgeview Health Care Center, Inc.

The Kent, Ltd.

Chesterfields, Ltd.

Out of State Facilities

Watch Hill Manor, Ltd.

The Clipper Home, Inc.

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

Name of Facility		License No.	Report for Year Ended		Page	of
The Kent, LTD		2147-C	9/30/2015		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended	Page	of		
The Kent, LTD	2147-C	9/30/2015	27	37		
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment \$						
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify) \$						
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) \$						
12. D. Other Interest Expense (Specify) \$ 6,071 6,071						
Interest on Term Note/Property Tax Interest						
13. Total All Interest Expense (12B7 + 12C3 + 12D) \$ 6,071 6,071						
14. Insurance						
a. Insurance on Property (buildings only) \$ 79,890 79,890						
b. Insurance on Automobiles \$						
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage) \$						
2. Fire and Extended Coverage \$						
3. Other (Specify) \$						
14d. Total Insurance Expenditures (14a + b + c) \$ 79,890 79,890						
15. Total All Expenditures (A-13 thru C-14) \$ 7,654,663 7,654,663						

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
The Kent, LTD				2147-C	9/30/2015	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$ 94,098	94,098		
7.			Other - See attached Schedule	\$ 36,000	36,000		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 569,202	569,202		
10.	15	1d/e	Accounting & Legal	\$ 8,543	8,543		
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m2/3	Unallowable Advertising *	\$ 8,462	8,462		
19.			Income Tax / Corporate Business Tax	\$			
20.	16	m10	Fund Raising / Contributions	\$ 1,415	1,415		
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 60,216	60,216		
Page 18 - Dietary Expenditures							
24.	30	IV1	Meals to employees, guests and others who are not residents	\$			
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 777,936	777,936		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

** Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	12m	Social Service/Marketing			
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B8	Medical Director (if no hours to support expense)	\$ 36,000		
Total Other Fees Adjustments			\$ 36,000	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Corporate Fee - Non Reimburable	\$ 26,878		
16	1.3	Employee Recognition/Gifts/Parties	\$ 15,377		
16	8a	Chamber of Commerce	\$ 125		
16	m13	Bank Charges	\$ -		
16	m13	Resident Expenses	\$ -		
16/30	m13/IV8	Account Write Off	\$ 17,836		
Total Other A&G Adjustments			\$ 60,216	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
The Kent, LTD			2147-C	9/30/2015	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 777,936	777,936		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$ 155,675	155,675		
28.			Ambulance/Limousine	\$ 40,128	40,128		
29.			X-rays, etc	\$ 33,605	33,605		
30.			Laboratory	\$ 1,182	1,182		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$ 12,095	12,095		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 12,288	12,288		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.	30	IV5	Interest Income on Accounts Rec	\$ 260	260		
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$ 6,071	6,071		
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51.	Total Amount of Decrease (Items 1 - 50)			\$ 1,039,240	1,039,240		

*** 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.

The Kent, LTD
9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	IV Therapy Supplies	\$ 9,620		
20	5j	Rehab Service Supplies	\$ 2,667		
Total Other Ancillary Costs			\$ 12,288	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	12D	Interest on Value Note	\$ 4,202		
27	12D	Inter on Property Taxes	\$ 1,869		
Total Other Adjustments			\$ 6,071	\$ -	\$ -

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
The Kent, LTD	2147-C	9/30/2015			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 3,122,486	3,122,486				
b. Medicaid Room and Board Contractual Allowance **	\$					
2. a. Medicaid (<i>All other states</i>)	\$ 350,594	350,594				
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 903,139	903,139				
b. Medicare Room and Board Contractual Allowance **	\$ 102,194	102,194				
4. a. Private-Pay Residents and Other	\$ 886,764	886,764				
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 80,272	80,272				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (80,272)	(80,272)				
c. Prescription Drugs - Non-Medicare	\$ 29,710	29,710				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (29,710)	(29,710)				
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	\$ 169,821	169,821				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (148,798)	(148,798)				
c. Physical Therapy - Non-Medicare	\$ 30,975	30,975				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (30,275)	(30,275)				
4. a. Speech Therapy - Medicare	\$ 38,072	38,072				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (20,363)	(20,363)				
c. Speech Therapy - Non-Medicare	\$ 3,465	3,465				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (3,465)	(3,465)				
5. a. Occupational Therapy - Medicare	\$ 188,461	188,461				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (154,162)	(154,162)				
c. Occupational Therapy - Non-Medicare	\$ 37,305	37,305				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (36,585)	(36,585)				
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$					
III. Total Resident Revenue (Section I. thru Section II.)	\$ 5,439,630	5,439,630				
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$ 260	260				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 30	30				
V. Total Other Revenue (1 thru 8)	\$ 290	290				
VI. Total All Revenue (III +V)	\$ 5,439,920	5,439,920				

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30 IV5	Interest Income	706,687	\$ 260		
Total Interest Income			\$ 260	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30	Account W/O	\$ 30		
Total Other Revenue		\$ 30	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
The Kent, LTD	2147-C	9/30/2015	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	2,985
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	706,687
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	30,141
5. Prepaid Expenses			\$	25,201
a. Prepaid Insurance	8,782			
b. Prepaid Property Tax	16,420			
c. Prepaid Other				
d.				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

A-9. Total Current Assets (Lines A1 thru 8)			\$	765,015
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>716,154</u>		\$	157,604
	Accum. Depreciation <u>558,549</u>	Net		
5. Non-Movable Equipment	*Historical Cost <u>418,745</u>		\$	30,928
	Accum. Depreciation <u>387,818</u>	Net		
6. Movable Equipment	*Historical Cost <u>743,532</u>		\$	143,919
	Accum. Depreciation <u>599,613</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	30,630
Construction in Progress	2,018			
Fixed Asset Clearing Account	28,612			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	363,080

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility The Kent, LTD	License No. 2147-C	Report for Year Ended 9/30/2015	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	1,128,095
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements			*Historical Cost _____	
			Accum. Depreciation _____	Net
			\$	
3. Buildings			*Historical Cost _____	
			Accum. Depreciation _____	Net
			\$	
4. Non-Movable Equipment			*Historical Cost _____	
			Accum. Depreciation _____	Net
			\$	
5. Movable Equipment			*Historical Cost _____	
			Accum. Depreciation _____	Net
			\$	
6. Motor Vehicles			*Historical Cost _____	
			Accum. Depreciation _____	Net
			\$	
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense			*Historical Cost _____	
			Accum. Depreciation _____	Net
			\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address		Amount	Loan Date	

7. Other Assets (<i>itemize</i>)			\$	1,400
Capitalized Refinance Expense		1,400		

D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	1,400
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	1,129,495

* 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 The Kent, LTD		License No. 2147-C	Report for Year Ended 9/30/2015	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	317,099
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>)				\$	68,414
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	27,025
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>)				\$	594,774
Accrued PTO		79,019	Accrued Worker's Comp	125,162	
Accrued Pension		1,152	Accrued Professional Fee	4,542	
Accrued Expense Other		115,109	Due Affiliate	263,301	
Payroll W/H		6,490			
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	1,007,312

* 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 The Kent, LTD	License No. 2147-C	Report for Year Ended 9/30/2015		Page 34	of 37
Account				Amount	
Total Brought Forward:				1,007,312	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					
				\$	
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$ 1,831,389	
Name and Address of Lender	Amount	Loan Date			
Brian J. Foley	1,831,389	Demand			
4. Other Long-Term Liabilities (<i>itemize</i>)				\$	
Security Deposit					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 1,831,389	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 2,838,701	

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Kent, LTD	2147-C	9/30/2015	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	8,293,787
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(7,789,249)
6. Gain or Loss for Period			\$	(2,214,743)
	10/1/2014	thru	9/30/2015	
7. Total Net Worth			\$	(1,709,206)
C. Total Reserves and Net Worth			\$	(1,709,206)
D. Total Liabilities, Reserves, and Net Worth			\$	1,129,495

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
The Kent, LTD	2147-C	9/30/2015	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2014			\$	(665,965)
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	5,439,920
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	7,654,663
D. Net Income or Deficit			\$	(2,214,743)
E. Balance			\$	(2,880,708)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
Brian Foley	1,175,000			
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	1,175,000
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	3,498
Name and Address <i>(No., City, State, Zip)</i>	Title	Amount		
Brian J. Foley	President	3,498		
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	3,498
H. Balance at End of Period			\$	(1,709,206)
				09/30/15

I. Preparer's/Reviewer's Certification

Name of Facility The Kent, LTD	License No. 2147-C	Report for Year Ended 9/30/2015	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Robert Gwizdak				
Address Address			Phone Number	
21 Waterville Road Avon, CT 06001			(860) 470-7535	

Error Check

Level	Item	Reported as	
-	Page 35 - Total Liabilities, Reserves and Net Worth	1,129,495	Total Assets 1,129,495