State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2016

Name of Facility (as licensed) Westfield Care & Rehab		
Address (No. & Street, City, State, Zip Code) 65 Westfield Rd Meriden CT 06450		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	980-C			07-5205

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	208367		

For Department Use Only

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

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General Information

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Westfield Care & Rehab	980-C	9/30/2016	1	37

Administrator's/Owner's Certification

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

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

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

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

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

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Westfield Care & Rehab	Period Covered:		From 10/1/2015	To 9/30/2016
Address of Facility 65 Westfield Rd Meriden CT 06450				
Report Prepared By Apple Health Care, Inc.	Phone Number (860) 678-9755		Date	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-238-1291	9/30/2016	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Westfield Care & Rehab	65 Westfield Rd Meriden CT 06450

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	980-C			07-5205

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

If this facility opened or closed during report year provide:	Date Opened	Date Closed

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Patty Hyppa	1079

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

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

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

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

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Westfield Care & Rehab	65 Westfield Rd Meriden CT 06450	Connecticut

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

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General Information and Questionnaire
Individual Proprietorship

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Brian J. Foley	21 Waterville Road Avon, CT	○	⊙		Real Estate Rental	Pg. 22 Line 9	720,000	720,000
Apple Health Care	21 Waterville Road Avon, CT	○	⊙		Management & Accounting Services	Pg. 16 Line m12	458,975	458,975
Healthport Services	21 Waterville Road Avon, CT	○	⊙		Employee Staffing	Pg. 10/13 Schedule	28,580	28,580
Allstar Therapy	21 Waterville Road Avon. CT	⊙	○	15%	Therapy Services	Pg. 13 B5/B9/B10	669,743	614,154
Corporate Employees	21 Waterville Road Avon, CT	○	⊙		Employee Staffing	Pg. 10 Schedule	13,969	13,969
Employees @ various Apple Facilities		○	⊙		Employee Staffing	Pg. 10 Schedule	14,103	14,103
Apple Health Care	21 Waterville Road Avon. CT	○	⊙		Pension Plan (401K)	Pg. 15 1a7	22,970	22,970
Aetna	PO Box 88860 Chicago, IL	⊙	○		Group Medical	Pg. 15 1a5	419,546	
Delta Dental	PO Box 23700 Newwark, NJ	⊙	○		Group Dental	Pg. 15 1a5	35,355	

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Westfield Care & Rehab	980-C	9/30/2016	4	37

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

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Aetna Ancillary	PO Box 88860 Chicago, IL	X			Group Life & Disability	Pg. 15 1a6	35,598	
Marsh	PO Box 19636 Newark, NJ	X			Property, Liability, & Umbrella Insura	Pg. 27 14a	106,632	
AIG	PO Box 10472 Newark, NJ	X			Worker's Compensation	Pg. 15 1a1	71,648	
Swallowing Diagnostics	21 Waterville Rd. Avon, CT	X		83%	Diagnostic Services	Pg. 20 5f	3,960	3,734
Brendan Foley	21 Waterville Rd. Avon, CT		X			##		
Ryan Vess	21 Waterville Rd. Avon, CT		X			##		
Patty Hyyppa	21 Waterville Rd. Avon, CT		X			Pg. 10 A2	30,777	30,777

* 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

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General Information and Questionnaire
Basis for Allocation of Costs

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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

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

N/A

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General Information and Questionnaire
Leases (Excluding Real Property)

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

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

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

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

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General Information and Questionnaire
Accounting Basis

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The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Blum Shapiro & Co. PC	29 South Main St. West Hartford, CT 06127
2 Brazee & Huban	35 Wendell Avenue Pittsfield, MA 10202
3	
4	

Services Provided by This Firm (*describe fully*)

1	Preparation of audited financials (dissallow Pg. 28)	$ 5,609
2	Preparation of tax returns	$ 2,069
3		$
4		$
		Charge for Services Provided $ 7,678

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

⊙ Yes ○ No | Pg. 15 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Law office - J. DeGenaro	
2 Various State Marshalls	
3 Treasurer-State of CT	
4 Clerk of Superior Court	
5 Pullman & Comley	

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

1 29 Water St Guilford CT
2
3 Meriden Probate Court, Meriden
4 Meriden Probate Court, Meriden
5

Services Provided by This Firm (*describe fully*)

1	Collection litigation	$ 53
2	Appointment of Conservator	$ 121
3	Appointment of Conservator	$ 300
4	Filing fees	$ 143
5	Real estate assessment filing	$ 43
		Charge for Services Provided $ 660

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

⊙ Yes ○ No Pg. 15 1e

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	100	100			100	100			100	100		
B. On last day of THIS report period	100	100			100	100			100	100		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	86	86			86	86			86	86		
B. As of midnight of THIS report period	84	84			84	84			84	84		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,292	1,292			1,066	1,066			226	226		
B. Medicaid (Conn.)												
C. Medicaid (other states)	24,327	24,327			18,336	18,336			5,991	5,991		
D. Private Pay	4,869	4,869			3,656	3,656			1,213	1,213		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	30,488	30,488			23,058	23,058			7,430	7,430		
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)**	30,488	30,488			23,058	23,058			7,430	7,430		

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Schedule of Resident Statistics (Cont'd)

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

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	4	61		19				
Per Diem Rate								
a. One bed rm.				434.00				
b. Two bed rms.	RUGS III	203.99		387.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	3,795	3,795		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	6,707	6,707		
D. ***Total Physical Therapy Treatments***	10,502	10,502		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	582	582		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	671	671		
D. ***Total Speech Therapy Treatments***	1,253	1,253		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	3,573	3,573		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	6,458	6,458		
D. ***Total Occupational Therapy Treatments***	10,031	10,031		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	98,531	2,168				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	43,665	2,599				
5. Dietary Service						
a. Head Dietitian	322	13				
b. Food Service Supervisor	54,579	2,366				
c. Dietary Workers	207,886	17,467				
6. Housekeeping Service						
a. Head Housekeeper	17,763	896				
b. Other Housekeeping Workers	115,461	9,988				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	169,718	9,254				
8. Laundry Service						
a. Supervisor	27,114	1,309				
b. Other Laundry Workers	53,262	4,098				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants	115,310	4,737				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	187,742	4,397				
b. RN						
1. Direct Care	379,671	10,406				
2. Administrative**	123,669	4,106				
c. LPN						
1. Direct Care	731,684	27,667				
2. Administrative**						
d. Aides and Attendants	1,139,342	74,070				
e. Physical Therapists	36,417	1,504				
f. Speech Therapists	6,041	191				
g. Occupational Therapists	15,211	466				
h. Recreation Workers	83,394	4,230				
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	90,255	3,706				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	3,697,036	185,638				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Data integrity auditor	$ 3,300	33				
Total	$ 3,300	33	$ -	-	$ -	-

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

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

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

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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
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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* **										
Renee Cole	67,754				Administrator 10/1/15 - 7/2/16	1,368	A 2			
Patricia Hyyppa	30,777				Administrator 7/3/16 - 9/30/16	800	A 2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
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	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	9,984	280				
3. Pharmacist	10,909	312				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	182,713	2,626				
b. Other						
6. Social Worker	143	6				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	18,780	87				
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)						
Misc physicians	962	34				
9. Speech Therapist						
a. Resident Care	56,300	313				
b. Other						
10. Occupational Therapist						
a. Resident Care	178,754	2,508				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	3,300	33				
B-13 Total Fees Paid in Lieu of Salaries	461,845	6,199				

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

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

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

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CSP-14 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
Westfield Care & Rehab	980-C	9/30/2016	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Allstar Therapy 21 Waterville Rd. Avon, CT	Therapy Services	⊙	○	See Disclosure Pg. 4
Healthport Services 21 Waterville Rd. Avon, CT	Employee Staffing	⊙	○	See Disclosure Pg. 4
West River 41 Northwest Dr. Plainville, CT	Pharmacist	○	⊙	
Joseph Tomanelli Meriden CT	Medical Director	○	⊙	
Healthdrive 25 Needham St Newton MA	Dentist and Podiatrist	○	⊙	
Cardiology Assoc of Central CT	Cardiologist	○	⊙	
Comprehensive Ortho	Orthopaedic	○	⊙	
Bristol Ortho	Orthopaedic	○	⊙	
HHC Physicians Care	Urologist	○	⊙	
Pointright	Data Integrity Auditor	○	⊙	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Westfield Care & Rehab	980-C	9/30/2016	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	71,648	71,648		
2. Disability Insurance	$				
3. Unemployment Insurance	$	48,423	48,423		
4. Social Security (F.I.C.A.)	$	258,228	258,228		
5. Health Insurance	$	329,262	329,262		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	35,598	35,598		
7. Pensions (Non-Discriminatory)	$	22,970	22,970		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	33,784	33,784		
d. Accounting and Auditing	$	7,678	7,678		
e. Legal (*Services should be fully described on Page 7)*	$	660	660		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	14,731	14,731		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	16,327	16,327		
2. Cellular Phones	$				
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$	250	250		
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	528,148	528,148		
Subtotal	$	1,367,705	1,367,705		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Westfield Care & Rehab	980-C	9/30/2016	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,367,705	1,367,705		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	7,333	7,333		
2. Holiday Parties for Staff	$	6,170	6,170		
3. Gifts to Staff and Residents	$	13,799	13,799		
4. Employee Travel	$	13,196	13,196		
5. Education Expenses Related to Seminars and Conventions	$	2,677	2,677		
6. Automobile Expense (*not purchase or depreciation*)	$	2,780	2,780		
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	40	40		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	3,105	3,105		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	4,013	4,013		
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	7,254	7,254		
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	648	648		
9. Subscriptions	$	603	603		
10. Contributions***	$				
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$	458,975	458,975		
13. Other (*Specify*)	$	76,916	76,916		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	1,965,213	1,965,213		

* 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	$ 3,105		
Total Other Advertising	$ 3,105	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Infection Control	$ 80		
CAHCF	$ 7,174		
Total Dues	$ 7,254	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Corporate Fees - Non Reimbursable	$ 40,666		
Licenses & Fees	$ 4,060		
Pre Employment Screening	$ 7,521		
Point Click Care Fees	$ 10,446		
Bank Charges	$ 184		
Resident Expenses	$ 7,766		
Account W\O	$ 1,473		
Prior Period Adj/Account W/O	$ (4,698)		
Civil Penalty- State of CT treasurer	$ 1,940		
Civil Penalty- Center of Med and Med Services	$ 1,800		
Healthport Indirect	$ 5,758		
Total Other Administrative and General	$ 76,916	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Westfield Care & Rehab	980-C	9/30/2016	17 | 37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Apple Health Care, Inc.	458,975	Accounting & Managerial Services	Pg. 16 m12

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

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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
Westfield Care & Rehab	980-C	9/30/2016	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	204,566	204,566		
2. Non-Food Supplies	$	36,846	36,846		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	1,258	1,258		
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	242,671	242,671		

2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals:	Total no. of meals served per day:*	251	251		

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

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

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CSP-19 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page
Westfield Care & Rehab	980-C	9/30/2016	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $	15,580	15,580		
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. $	10,318	10,318		
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)	$	25,897	25,897		

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

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

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

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

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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
Westfield Care & Rehab	980-C	9/30/2016	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	35,857	35,857		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	35,857	35,857		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from West River Pharmacy		$	121,269	121,269		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	289,812	289,812		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	38,884	38,884		
f. X-rays and Related Radiological Procedures***		$	15,858	15,858		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	11,557	11,557		
i. Recreation		$	28,393	28,393		
j. Other (Specify)**** See Attached Schedule		$	44,672	44,672		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	550,447	550,447		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Nursing Station Supplies	$ 3,919		
Rehab Service Supplies	$ 1,898		
IV Therapy Supplies	$ 38,854		
Social Service Supplies	$ -		
Total Other Resident Care	$ 44,672	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Westfield Care & Rehab	980-C	9/30/2016	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
CWPM	25 Norton Pl Plainville CT	○	⊙		Refuse Removal	24,451			22	6 f
Perfectemp	635 Old Turnpike Rd Plantsville, CT	○	⊙		Heating \ Cooling	13,891			22	6 a
Roy's Landscaping	PO Box 224 Portland CT	○	⊙		Snow removal	23,450			22	6 a
West State Mechanical	3000 S Main Torrington CT	○	⊙		Elevator Service	11,287			22	6 a
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Westfield Care & Rehab	980-C	9/30/2016	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	139,018	139,018		
b. Heat	$	42,750	42,750		
c. Light & Power	$	66,438	66,438		
d. Water	$	24,107	24,107		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	26,874	26,874		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	299,187	299,187		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$				
d. Movable Equipment	$	13,475	13,475		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	13,475	13,475		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	26,719	26,719		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	26,719	26,719		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	720,000	720,000		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	42,596	42,596		
c. Personal property taxes	$	3,838	3,838		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	806,627	806,627		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Refuse Removal	$ 26,874		
Total Other Repairs and Maintenance	$ 26,874	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Westfield Care & Rehab	980-C	9/30/2016	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	23,637		23,637	23,637	S\L	var		
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								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					344,198		344,198	306,976	S\L	var	13,475	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)												
D-3. Subtotal												13,475
E. ***Total Depreciation***												13,475

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Schedule of Land Improvements Acquired during this report period

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

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

Schedule of Building Improvements Acquired during this report period

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

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

Schedule of Non-Movable Equipment Acquired during this report period

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

***Ties to Page 23, Line C3**
****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report period

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

***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:					
1/4/2016	2 Expansion joints for Boiler	$ 3,557	10	$ 133	
3/28/2016	Door and frame installation to Wing 1	$ 2,689	15	$ 60	
Total additions for Leasehold Improvement		$ 6,246		$ 193	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Westfield Care & Rehab	980-C	9/30/2016	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period				1,056,438	905,936	A		26,526	
2. Disposals (attach schedule)									
3. Acquired during this report period									
(attach schedule)				6,246				193	
C-4. Subtotal									26,719
D. ***Total Amortization***									26,719

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Westfield Care & Rehab	980-C	9/30/2016	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	100
6. Square Footage	
7. Acquisition Cost	
a. Land	
b. Building	

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

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

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

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

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

Connecticut Facilities

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

Out of State Facilities

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Westfield Care & Rehab	980-C	9/30/2016	26 | 37

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

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Westfield Care & Rehab	980-C	9/30/2016	27 | 37

Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment 1. Automotive Equipment		$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (*Specify*)		$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		$				
12. D. Other Interest Expense (*Specify*) Value settlement $669 late pmt taxes $1,372		$	2,041	2,041		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)		$	2,041	2,041		
14. Insurance						
a. Insurance on Property (buildings only)		$	106,632	106,632		
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)***		$	106,632	106,632		
15. ***Total All Expenditures (A-13 thru C-14)***		$	8,193,454	8,193,454		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Westfield Care & Rehab	980-C	9/30/2016	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.	10	A12g	Occupational Therapy $	15,211	15,211		
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	B10a	Occupational Therapy $	178,754	178,754		
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	33,784	33,784		
10.	15	1d/e	Accounting & Legal $	6,269	6,269		
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 * $	3,105	3,105		
19.			Income Tax / Corporate Business Tax $				
20.	16	m10	Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	58,365	58,365		
Page 18 - Dietary Expenditures							
24.	30	IV1	Meals to employees, guests and others who are not residents $	301	301		
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) $	295,789	295,789		

* 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)
Total Other Salaries Adjustment			$ -	$ -	$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Corporate Fee - Non Reimbursable	$ 40,666		
16	1.3	Employee Recognition/Gift/Parties	$ 13,799		
16	8a	Chamber of Commerce	$ 648		
16	m13	Bank Charges	$ 184		
16	m13	Resident Expenses	$ 7,766		
16	m13	Prior Period Adj/Account W/O	$ (4,698)		
16	m13	Account W\O	$ 1,473		
16	m13	Civil Penalty- State of CT treasurer	$ 1,940		
16	m13	Civil Penalty- Center of Med and Med Services	$ 1,800		
Total Other A&G Adjustments			$ 58,365	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page
Westfield Care & Rehab	980-C	9/30/2016	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	295,789	295,789		
Page 20 - Resident Care Supplies***								
27.	20	5a2	Prescription Drugs	$	121,269	121,269		
28.	16	L1	Ambulance/Limousine	$	7,333	7,333		
29.	20	h	X-rays, etc	$	15,858	15,858		
30.	20	f	Laboratory	$	11,557	11,557		
31.			Medical Supplies	$				
32.	20	5e2	Oxygen (non emergency)	$	32,558	32,558		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	40,753	40,753		
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.	30	IV 4	Radio and Television Revenue	$	5,910	5,910		
44.			Vending Machine Revenue	$				
45.	30	IV 8	Purchase Discounts and Allowances	$	23,580	23,580		
46.			Duplications of functions or services	$				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	$				
48.	30	IV 5	Interest Income on Accounts Rec	$	73	73		
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	$	2,041	2,041		
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)***	$	556,721	556,721		

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

Attachment Page 29

Westfield Care & Rehab
9/30/2016

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	IV Therapy Supples	$ 38,854		
20	5j	Rehab Service Supplies	$ 1,898		
Total Other Ancillary Costs			$ 40,753	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	12 D	Value Settlement	$ 669		
27	12 D	Late pmt interest	$ 1,372		
Total Other Adjustments			$ 2,041	$ -	$ -

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Westfield Care & Rehab	980-C	9/30/2016	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	4,854,600	4,854,600		
b. Medicaid Room and Board Contractual Allowance **	$				
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	547,568	547,568		
b. Medicare Room and Board Contractual Allowance **	$	234,158	234,158		
4. a. Private-Pay Residents and Other	$	1,699,911	1,699,911		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	51,175	51,175		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(51,135)	(51,135)		
c. Prescription Drugs - Non-Medicare	$	73,051	73,051		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(73,051)	(73,051)		
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	$	263,167	263,167		
b. Physical Therapy - Medicare Contractual Allowance **	$	(154,231)	(154,231)		
c. Physical Therapy - Non-Medicare	$	104,405	104,405		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(101,395)	(101,395)		
4. a. Speech Therapy - Medicare	$	39,736	39,736		
b. Speech Therapy - Medicare Contractual Allowance **	$	(18,256)	(18,256)		
c. Speech Therapy - Non-Medicare	$	16,650	16,650		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(16,650)	(16,650)		
5. a. Occupational Therapy - Medicare	$	329,356	329,356		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(197,491)	(197,491)		
c. Occupational Therapy - Non-Medicare	$	122,040	122,040		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(120,825)	(120,825)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	16,680	16,680		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	7,619,463	7,619,463		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	301	301		
2. Rental of rooms to non-residents	$				
3. Telephone	$	720	720		
4. Rental of Television and Cable Services	$	5,910	5,910		
5. Interest Income *(Specify)*	$	73	73		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	23,840	23,840		
V. Total Other Revenue (1 thru 8)	$	30,844	30,844		
VI. Total All Revenue (III +V)	$	7,650,306	7,650,306		

* *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)
30 IV 8	Optum - Glucose Lab	$ 16,680		
Total Other Resident Revenue		$ 16,680	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30 IV5	Interest Income	1,125,830	$ 73		
Total Interest Income			$ 73	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV 8	Rebates	$ 23,580		
30 IV 8	Medical records	$ 260		
Total Other Revenue		$ 23,840	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Westfield Care & Rehab	980-C	9/30/2016	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 1,211
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,125,830
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 11,255
5. Prepaid Expenses				$ 968
a. Prepaid Insurance				
b. Prepaid Property Tax		968		
c. Other Prepaid Expenses				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 55,224
Due Affiliate (Debit Balance)		55,224		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,194,488
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	1,062,684		$ 130,029
	Accum. Depreciation	932,655	Net	
5. Non-Movable Equipment	*Historical Cost	23,637		$
	Accum. Depreciation	23,637	Net	
6. Movable Equipment	*Historical Cost	344,198		$ 23,747
	Accum. Depreciation	320,451	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
Fixed Asset Clearning Account				
Construction in Progress				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 153,776

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Westfield Care & Rehab	980-C	9/30/2016	32	37

Account				Amount
			Total Brought Forward:	$ 1,348,264
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$
Loans Rec. - Officers/Owner				
Capitalized Refinance Expense				
Leasehold Deposits				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 1,348,264

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Westfield Care & Rehab	980-C	9/30/2016	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 283,440
2. Notes Payable (*itemize*)					$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)					$ 86,533
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 15,195
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$ 432,606
Accrued PTO	155,894	Accrued Professional Fee	6,158		
Accrued Pension	4,714	Payroll W/H	1,943		
Accrued Worker's Comp	112,171	Due Affiliate (Credit Bal			
Accrued Expense Other	150,080	Exchange Accounts	1,645		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 817,774

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Westfield Care & Rehab	980-C	9/30/2016	34	37

Account	Amount
Total Brought Forward:	817,774
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$ 1,295,848

Name and Address of Lender	Amount	Loan Date
Brian J. Foley	1,295,848	Demand

4. Other Long-Term Liabilities (*itemize*)	$
Security Deposits	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 1,295,848
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 2,113,623

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

Name of Facility	License No.	Report for Year Ended	Page	of
Westfield Care & Rehab	980-C	9/30/2016	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$ 7,378,855
	2. Capital Stock	$ 1,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (7,602,066)
	6. Gain or Loss for Period 10/1/2015 thru 9/30/2016	$ (543,147)
	7. Total Net Worth	$ (765,359)
C.	***Total Reserves and Net Worth***	$ (765,359)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 1,348,264

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Westfield Care & Rehab	980-C	9/30/2016	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2015			$ (1,092,309)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 7,650,306
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 8,193,454
D.	Net Income or Deficit			$ (543,147)
E.	Balance			$ (1,635,456)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Brian Foley	875,000		
	2. Other (*itemize*)			
F-3.	Total Additions			$ 875,000
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$ 4,902

Name and Address (*No., City, State, Zip*)	Title	Amount
Brian Foley	President	4,902

	2. Other Withdrawings *(Specify)*		$
	Purpose	Amount	
	3. Total Deductions		$ 4,902
H.	***Balance at End of Period*** 09/30/16		$ (765,358)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Westfield Care & Rehab	980-C	9/30/2016	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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.

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
Robert Gwizdak

Addres Address	Phone Number
21 Waterville Road Avon, CT 06001	(860) 470-7535