Craig J. Lubitski Consulting in & CJLC inc

CERTIFIED PUBLIC ACCOUNTANTS & ADVISORS

Mr. Chris LaVigne **CON & Reimbursement Department of Social Services** 55 Farmington Avenue Hartford, CT 06105

Mr. LaVigne:

This enclosed 2015 Medicaid Cost Report intentionally omits the following disallowances:

- a. Administrator and Related Party salaries
- b. Dues and Membership Fees to Professional Associations
- c. Physical or Speech Therapy salaries or fees
- d. Depreciation and/or interest expense related to capitalized items previously deemed unallowable by the Department

It is our understanding that the software utilized by the Department in the rate setting process computes the necessary disallowances for these areas and our intention is to eliminate the potential for a duplicate disallowance.

If you have any questions, please contact me at 860-610-9009.

Respectfully,

ピタス

Craig J. Lubitski, CPA

Partner

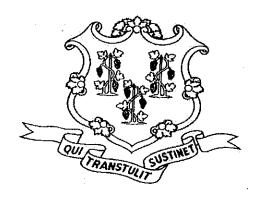
cjlc.com



225 Pitkin Street East Hartford Connecticut 06108

860.610.9009 (t) 860.610.9030 (f)

State of Connecticut



Annual Report of Long-Term Care FacilityCost Year 2015

Name of Facility (as I	•							
Newfield Rest Home		····						
Address (No. & Stree		-						
876 Newfield Street,	Middletown, C	T 06457	****					
Type of Facility								
Chronic and C	Convalescent		Rest Home wit	h Nursing				
☐ Nursing Home	e only		Supervision on	ıly	\checkmark	Residentia	al Ca	re Home
(CCNH)	•		(RHNS)					
Report for Year Begi	nning		Report for Year	r Ending				
10/1/2014			9/30/2015					
License Numbers:		CCNH	RHNS	Reside	ential Care 1845	Home	Me	dicare Provider
Medicaid Provider N	umbers:	CC	CNH	RF	ĪNS		IC:	F-IID
For Department Use	e Only							
Sequence Number	Signed and	Date	Sequence N		Signed	and Notari	zed	Date Received
Assigned	Notarized	Received	Assign	ed	Digited (2410 110001104
						·		

Table of Contents

Gen	eral Information - Administrator's/Owner's Certification	1
Gen	eral Information and Questionnaire - Data Required for Real Wage Adjustment	1A
Gen	eral Information and Questionnaire - Type of Facility - Organization Structure	2
Gene	eral Information and Questionnaire - Partners/Members	2
Gen	eral Information and Questionnaire - Corporate Owners	3A
Gene	eral Information and Questionnaire - Individual Proprietorship	3B
Gene	eral Information and Questionnaire - Related Parties	4
Gene	eral Information and Questionnaire - Basis for Allocation of Costs	5
Gene	eral Information and Questionnaire - Leases	6
Gene	eral Information and Questionnaire - Accounting Basis	7
Sche	edule of Resident Statistics	8
Sche	edule 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
Н.	Changes in Total Net Worth	36
I.	Preparer's/Reviewer's Certification	37

State of Connecticut

Annual Report of Long-Term Care Facility
CSP-1 Rev.9/2002

General Information

Y-1				
Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Newfield Rest Home, Inc.	1845	9/30/2015	1	37

Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR 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 Newfield Rest Home, Inc. [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 (Administratory)	**************************************	Date 2/2/16	Signed (Owner)	UDLU DATO
Printed Name (Administrator) Paul Hotkowski			Printed Name (Owner) Paul & Donna Hotkowski	
to before me.	State of	Date 2/2/16	Signed (Notary Public)	Comm. Expires 8/31/18
Address of Notary Public 47 SUSTUL ANL,	Wlsthnov	K. Ct O	1,498	

(Kotary Seal)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-1A Rev. 6/95

State of Connecticut Department of Social Services 25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjus	tm	ent		Page 1A	of 37
Name of Facility		Period Cov	ered:	From	То
Newfield Rest Home, Inc.				10/1/2014	9/30/2015
Address of Facility 876 Newfield Street, Middletown, CT 06457					
Report Prepared By Craig J. Lubitski Consulting LLC		Phone Nun 860-610-90		Date 2/5/2016	
Item		Total	CCNH	RHNS	Residentia 1 Care Home
1. Dietary wages paid	\$				
2. Laundry wages paid	\$,			
3. Housekeeping wages paid	\$				ļ
4. Nursing wages paid	\$				
5. All other wages paid	\$				
6. Total Wages Paid	\$				
7. Total salaries paid	\$		<u> </u>		
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$				<u> </u>

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.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-2 Rev. 10/2005

General Information and Questionnaire

Type of Facility - Organization Structure

		Pho	ne No. of Fa	cility	Report for Ye	ar Ended	Page		of
		860	-632-2118		9/30/2015		2		37
Name of Facility (as shown on license)			Address (N	o. & S	Street, City, Sto	te, Zip)			
Newfield Rest Home, Inc.		, .			eet, Middletov				
·	CCNH		RHNS	Resi	dential Care H		Medicare I	rovio	ler No.
License Numbers:					1	845			
Type of Facility (Check appropriate box(es))									
Chronic and Convalescent Nursing Home only (CCNH)			t Home with ervision only			Residenti	ial Care Hor	ne	
Type of Ownership (Check appropriate box)									
O Proprietorship O LLC O Parti	ıership	0	Profit Corp.		Non-Profit Con		Government	0	Trust
If this facility opened or closed during report ye	ar provide	e:		Date	Opened	Date Clo	sed		
Has there been any change in ownership				·					
or operation during this report year?		0	Yes	•	No	If "Yes,"	explain full	у.	
Administrator	-								
Name of Administrator					Nursing Ho				
Paul Hotkowski					Administrat	1			
	• • • •	/O 11		0.1	License N	No.:			
Other Operators/Owners who are assistant admi	nistrators	(ful	or part time	of th		T			
Name					License 1	NO.:			
								-	
								•	

State of Connecticut Annual Report of Long-Term Care Facility CSP-3 Rev. 10/2005

General Information and Questionnaire Partners/Members

Name of Facility Newfield Rest Home, Inc.		License No. 1845	Report for Y 9/30/2015	ear Ended	Page of 3
Legal Name of Parti	nership/LLC	Business A			or Town(s) in egistered
Name of Partners/Members	Business Ad	ldress		Γitle	% Owned

General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year Er	nded	Page of
Newfield Rest Home, Inc.	1845	9/30/2015		3A 37
If this facility is owned or operated as a cor				
Legal Name of Corporation		ess Address	}	ich Incorporated
Newfield Rest Home, Inc.	876 Newfield St CT 06457	reet, Middletown,	СТ	
Name of Directors, Officers	Busine	ess Address	Title	No. Shares Held by Each
Paul Hotkowski	138 Fairview Ro 06498	oad, Westbrook, CT	President	N/A
Donna Hotkowski	138 Fairview Ro 06498	oad, Westbrook, CT	Secretary	N/A
Names of Stockholders Owning at Least 10% of Shares				
Paul Hotkowski	138 Fairview Ro 06498	oad, Westbrook, CT	President	50
Donna Hotkowski	138 Fairview Ro 06498	ad, Westbrook, CT	Secretary	50

State of Connecticut

Annual Report of Long-Term Care Facility
CSP-3B Rev. 10/2005

General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Newfield Rest Home, Inc.	1845	9/30/2015	3B	37
If this facility is owned or operated as an individua	ıl proprietorship, r	provide the following informa	rtion'	
Ow	ner(s) of Facility		-40	-
	(-)			
	·			
		VIII -		
	····			
	·····	****		
			·····	
				-
			ч	

State of Connecticut Annual Report of Long-Term Care Facility CSP-4 Rev. 10/2005

General Information and Questionnaire Related Parties*

Name of Facility Newfield Rest Home Inc		License No.	No.	Report for Year Ended 9/30/2015		Page 4	of 3.7

Are any individuals rece	Are any individuals receiving compensation from the facility related through	cility rela	roug	d Vev C	If "Yes," provide the Name/Address and	e Name/Add	ress and
marriage, acmey to com	ion, ownership, terming or ownership	700000		3	with the distriction	יייייייייייייייייייייייייייייייייייייי	
Are any individuals or c	Are any individuals or companies which provide goods or services,	or servic	es,				
including the rental of prelated through family a	including the rental of property of the loaning of tinds to this facility, related through family association, common ownership, control, or business	control,	anty, or business	O Yes O No			
association to any of the	association to any of the owners, operators, or officials of this facility?	of this fa	ility?		If "Yes," provide the following information:	e following i	nformation:
		Also	Also Provides		Indicate Where		
		Goods	Goods/Services to		Costs are Included		
Name of Related	Business	Non-Re	Non-Related Parties	S Description of Goods/Services	in Annual Report	Cost	Actual Cost to the
Individual or Company	Address	Yes	**% oN	Provided	Page # / Line #	Reported	Related Party
	138 Fairview Road, Westbrook, CT		_				
Paul & Donna Hotkowski	06498)))	Rental of Real Estate	22/9	2,929	2,929
Paul & Donna Hotkowski	138 Fairview Road, Westbrook, CT 06498	0	•	Loan	34/B3	(34,920)	(34,920)
	86 Fairview Road, Westbrook, CT	C	•				
Nicholas Hotkowski	06498)	•	Loan	10/A7B	6,628	6,628
Kaitlyn Hotkowski	86 Fairview Road, Westbrook, CT 06498	0	•	Office Clerical	10/A4	526	526
	86 Fairview Road, Westbrook, CT 06498	0	0				
		0	0				
		0	0				
		0	0				
		0	0				
* Use additional sheets if necessary	s if necessary			-			

^{*} Use additional sheets if necessary.

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

General Information and Questionnaire Basis for Allocation of Costs

Name of Facility	License No),	Report for Year Ended	Page of
Newfield Rest Home, Inc.	1845		9/30/2015	5 37
If the facility is licensed as CDH and/or RCH o	r provides A	IDS or TB	I services with special Medic	aid rates, costs
must be allocated to CCNH and RHNS as follo				
Item			Method of Allocatio	n
Dietary		Number of	meals served to residents	
Laundry		Number of	pounds processed	
Housekeeping			square feet serviced	
			hours of routine care provide	_
Nursing		employee o	classification, i.e., Director (c	or Charge Nurse),
		Registered	Nurses, Licensed Practical N	Jurses, Aides and
		Attendants		
Direct Resident Care Consultants		Number of	hours of resident care provide	led by EACH
			(See listing page 13)	
Maintenance and operation of plant		Square feet		
Property costs (depreciation)		Square feet		
Employee health and welfare		Gross salar		
Management services			e cost center involved	
All other General Administrative expenses			rect and Allocated Costs	
The preparer of this report must answer the foll	owing quest	ions applica	able to the cost information p	rovided.
1. In the preparation of this Report, were all	O Yes	O No	If "No," explain fully why su	uch allocation was
costs allocated as required?	• Yes	C) IND	not made.	
2. Explain the allocation of related company ex	penses and	attach copy	of appropriate supporting da	ita.
3. Did the Facility appropriately allocate and se	lf-disallow	direct and i	ndirect costs to non-nursing l	nome cost centers?
(e.g., Assisted Living, Home Health, Outpati				
-			If "No," explain fully why su	ich allocation was
	• Yes	O 110	not made.	ton uncountry was
			not made.	

Annual Report of Long-Term Care Facility State of Connecticut CSP-6 Rev. 9/2002

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		1.1	License No.	Report for Year Ended	ear Ended		Page of
Newfield Rest Home, Inc.			1845	9/30/2015			6 37
	Related * to	to t	AMERICAN AND AND AND AND AND AND AND AND AND A				
	Owners,						
	Operators,	Š. '		J. 242.C	e E	Annual	,
EQ. TY V.	3	ا م	T		161111 01	Allount	Amount
Name and Address of Lessor	Yes	S S	Description of Items Leased	Lease**	Lease	ot Lease	Claimed
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					:
	0	0					
	0	0					-
	0	0		·			
	0	0					
	0	0					
Is a Mileage Log Book Maintained for All Leased Vehicles?	Leased Vehi	cles?	O Yes	•	o No	Total ***	

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

*** Amount should agree to Page 22, Line 6e.

^{**} Attach copies of newly acquired leases.

General Information and Questionnaire **Accounting Basis**

Name of Facility	License No.	Report for Year Ended		Page	of
Newfield Rest Home, Inc.	1845	9/30/2015		7	37
The records of this facility for the p	period covered by this report	t were maintained on the following basis:			
Accrual O Cash O	Modified Cash				
Is the accounting basis for this					
I *	Yes	If "No," explain.			
previous period? O	No				
Independent Accounting Firm					
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)			
1 Craig J. Lubitski Consulting Ll	LC	225 Pitkin Street, East Hartford, CT 0610	08		
2					
3					
4 Services Provided by This Firm (<i>de</i>	escriba fullu		•		
Monthly Bookkeeping, Medicaid Cos	t Report Preparation, Audit Supp	ort & Taxes	\$	8,615	
2		APPROXIMATE TO A PROXIMATE TO A PROXIMATE	\$		
3			\$		
4		***************************************	\$		
			Charge fo	r Services Pr	ovided
		·	\$	8,615	
		Yes, Specify Expense Classification and Line No.			
	15/1d				
Legal Services Information Name of Legal Firm or Independent	t Attauman		Talamban	NI. mala au	
1 Cloutier & Cassella	t Attorney		Telephone 860-388-3		
2			800-386	1430	
3					
4		•			
5			,		
Address (No. & Street, City, State, 2	Zip Code)				
1 29 Elm St., Old Saybrook, CT					
2					
3					
4					
5 Services Provided by This Firm (de.	scribe fully)				
	 	14.16			
	ider, Drait transfer documents for	14-13	\$	300	
2			\$		
3			\$		
5			\$		
5		7-7-4-110-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	\$	<i>a</i> , b	• • • •
			Charge to	r Services Pr 300	ovided
Are These Charges Reflected in the Expend	diture Portion of This Report? If	Yes, Specify Expense Classification and Line No.	J	223	
	Page 15/1e	· ·			

State of Connecticut Annual Report of Long-Term Care Facility CSP-8 Rev. 9/2002

Schedule of Resident Statistics

Name of Facility			License No.	do.			Report fo	Report for Year Ended	773		Page	jo
Newfield Rest Home, Inc.			1	1845			9/30/2015				∞	37
· · · · · · · · · · · · · · · · · · ·						Period 10/1 Thru 6/30	1 Thru 6/	30		Period 7/1	Thru 9/30	0
	Total All	Total CCNH	Total RHINS	Total Residential				Residential				Residential
	Levels	Level	Level	Care Home	Total	CCNH	RHNS	Care Home	Total	CCNH	RHINS	Care Home
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	14			14	14			14	14			14
B. On last day of THIS report period	14			14	14			14	14			14
2. Number of Residents												
A. As of midnight of PREVIOUS report period	14			14	14			14	14			14
B. As of midnight of THIS report period	14			14	14			14	14			14
3. Total Number of Days Care Provided During Period												
A. Medicare												
B. Medicaid (Conn.)												
C. Medicaid (other states)												
D. Private Pay												
E. State SSI for RCH	5,078			5,078	3,790			3,790	1,288			1,288
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	5,078			5,078	3,790			3,790	1,288			1,288
Total Number of Days Not Included in Figures in 3G												
									·			
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	5,078			5,078	3,790			3,790	1,288			1,288

State of Connecticut **Annual Report of Long-Term Care Facility**CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Faci	lity			Lice	nse No.				Repor	t for Year	Ended		Page	of
Newfield Res	t Home	, Inc.			1845					9/30/201			9	37
			in the certified b		pacity du	ring tl	he repo	ort yea	r?	·	Yes	0	No	<u> </u>
If "YES"	7		llowing informa	tion:										
		Place of	f Change		Cl	nange	in Bed	s		Ca	pacity Aft	er Change		
5. 0			Residential		_									
Date of	CCNH	RHNS	Care Home		Lost			Gaine	d	.				
Change	(1)	(2)	(2)	(1)	(2)	(2)	(1)	(m)	(2)	CONTI	DIDIO	Residential		a
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Care Home	Reason	for Change
	 							 					 	
										-				•
										<u> </u>	·····			······
5 TC:1														
			in certified bed o 90 days followir			the re	eport ye	ear (as	report	ted in item	4 above)	provide the nur	mber of	
			Change in Re	esiden	t Days					CC	NH	RHNS	Residentia	l Care Home
1st chang										<u> </u>				
2nd chan 3rd chan										<u> </u>				
4th chang														
		lents and	d Rates on Septe	mber	30 of Co	st Yea	nr			<u> </u>			<u> </u>	
			Medicare		Medic		1			Se	lf-Pay		Other Sta	te Assisted
		Ī												
		I								l		Residential	İ	
	Item		CCNH	C	CNH	RH	INS	CC	NH	RH	NS	Care Home	R.C.H.	ICF-IID
No. of Re	esidents													
Per Diem				60.66										
a. One b													90.00	
b. Two b														
c. Three		;					i							
bed m	ms.	- 1								 				
														D i d i . 1
7. Total Nu	mber of	Physica	l Therapy Treati	nents						TO	ral	CCNH	RHNS	Residential Care Home
		re - Part								10.	710	CCIVII	KIIIQ	Cate Home
			usive of Part B)											
			Treatments									Product of State of S		A Property of the Control of the Con
		orative [Freatments											
	Other		TI T											
			Therapy Treatm Therapy Treatm											
		re - Part		ems										
			usive of Part B)											
			Treatments											
			Freatments					-						
	Other													
			herapy Treatme											
			tional Therapy T	reatm	ents									
		re - Part	B usive of Part B)											VILLEY COMPANY OF THE PARTY OF
			Treatments											
			Freatments											
	Other													
		ccupatie	onal Therapy Ti	eatm	ents						i			

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Report of Ex	^ 	Dalain			1 D.	_ c
Name of Facility	License No.		Report for Yea	r Ended	Page	of
Newfield Rest Home, Inc.	1845		9/30/2015		10	37
Are time records maintained by all individuals receiving co	mpensation?	•	Yes	0	No	
			Total Cost a	and Hours		
	324		1041.000.			
					Residential	
Item	CCNH	Hours	RHNS	Hours	Care Home	Hours
A. Salaries and Wages*	- 301111					
Operators/Owners (Complete also Sec. I						
of Schedule A1)	W. C.					
2. Administrator(s) (Complete also Sec. III						
of Schedule A1)					51,407	2,080
3. Assistant Administrator (Complete also Sec. IV						
of Schedule A1)						
4. Other Administrative Salaries (telephone						
operator, clerks, receptionists, etc.)	Leave and the second				14,348	1,221
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor c. Dietary Workers			 	<u> </u>	19,955	1,700
6. Housekeeping Service	_				1,533	1,700
a. Head Housekeeper	HARMAN SCHOOL STATE					
b. Other Housekeeping Workers					14,958	1,274
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						*****
b. Other Maintenance Workers					28,732	2,474
8. Laundry Service						
a. Supervisor			<u> </u>	+	9,972	849
b. Other Laundry Workers 9. Barber and Beautician Services	-				9,912	04.
Protective Services				<u> </u>		
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
 a. Directors and Assistant Director of Nurses 						
b. RN						
Direct Care				ļ		
2. Administrative**		t omeaning state of				
c. LPN						
Direct Care Administrative**		<u> </u>	 	1		
d. Aides and Attendants			<u> </u>		47,883	4,07
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists			ļ			
h. Recreation Workers				2 1128/02/02/02/03/03	6,985	59.
i. Physicians						
1. Medical Director			-			
Utilization Review Resident Care***		<u> </u>	ļ		-	
4. Other (Specify)						
T. Other (Specify)		210000000000000000000000000000000000000		and the second s		The second secon
j. Dentists						
k. Pharmacists						
I, Podiatrists		<u> </u>				
m. Social Workers/Case Management		1	 	ļ	+	
n. Marketing	1	1				
			THE RESERVE THE PARTY OF THE PA	A SHADOW NEWSCOOL PROCESSES		
o. Other (Specify) See Attached Schedule						

^{*} 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)

		CNH	RI	INS	Residential	Care Home
Position	\$	Hours	\$	Hours	\$	Hours
		de trait e provinción a natifi				
					Yani in an	No. 10 and 10 an
	856 / 645 (476 (476 (476	3 45 45 11 30 3			100000000000000000000000000000000000000	
						Branca (Special Sp
		0.0000000000000000000000000000000000000		0.53 (150 (150 (150 (150 (150 (150 (150 (150	98799208080808	200 VIII AAA 00 VIII A
	100000000000000000000000000000000000000					
					No. 15	
	TOSSIVANI VERVINA NAZ	20.020.000.000.000.00		9886 GEORGE ACTIONS		\$150.000 (Sec. 9)
	1 1/40/25 (20/20/20)			Name of the second		
			150 Aug 100 Aug			
	- 0.000,000,000,000		14,000 (20,000)		100 PM 100 PM 100 PM	source its decision
		Salay is a salay salay		3,40,700,000,000	100 (1) (100 At 100 A	7. S. 10. St. 4
				(C. (C. (C. (A)))	as contract asse	
					44.000	
Cotal Cotal	\$ -	A	\$ -	1000 Company	\$ -	in a second second

Schedule of Other Fees (Page 13)

	cc	CNH	RI	INS	Residential	Care Home
Service	\$	Hours	\$	Hours	\$	Hours
					2 0000000000000000000000000000000000000	150000000000000000000000000000000000000
				11 (40 (40 (40 (40 (40 (40 (40 (40 (40 (40		
				10 (10 (10 (10 (10 (10 (10 (10 (10 (10 (
	0.55 (\$.555.5)					7000 (800)
		100 45 000 000 120				100000000000000000000000000000000000000
		(See Section of the Control	100 (100 (100 (100 (100 (100 (100 (100	Terror		
		100 000 000 000 000 000 000 000 000 000		100000000000000000000000000000000000000		(10.50 PP (0.50 1.00 1.00 1.00 1.00 1.00 1.00 1.00
	e energy state European					
			- 30.00 40.050.40	Company of the	5 (32.034 valengt) (32.034 v	100000000000000000000000000000000000000
	0.0000000000000000000000000000000000000					
			3133 (60.3)			
	7 (2) (2) (2)	SECRETARY OF THE ANALYSIS		Larran Physics and the		
				Year Control of the C		
		54 NO. 10 NO. 10 NO.		Notation and the second	actions at the	e ca se atriba
			7.50 (3	A SECTION SECTION	24 (6) (2) (3)	SAN DE STATUTO
	0.0000000000000000000000000000000000000			20 90 U.S. S. S. S.	7000 TREATURE 1	V. 1974 Q 1. 1974 445 C
l'otal	\$	100 St. (1) 10 St.	\$	697000000000000000000000000000000000000	\$ -	3 (5 / 6) (5) (5)

State of Connecticut

Annual Report of Long-Term Care Facility CSP-11 Rev. 10/2005

Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties*

Name of Facility		7	Assistant	License No.	ASSISTANT ACMINITISTATORS AND OLDER REJACTOR FAILURS	Report for	Report for Year Ended		Page	of
Newfield Rest Home, Inc.				1845		9/30/2015	٠			37
		Salary Paid	þ							
Name	CCNH	RHNS	Residential Care Home	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
Section I - Operators/Owners										
and an artist and a state of the state of th				A Address of the Control of the Cont						
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).										
Hotkowski, Kaitlyn			526		Office Clerical	44	44 A-4			
Hotkowski, Nicholas			6,628		Maintenance	552	552 A-7B			

* No allowance for celesiae will be considered unless full information is movided. Her additional sheets if remitted	he consider	ad unless fi	.11 information	air peorided 110a	additional sheets if rea	ired				

^{*} 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.

State of Connecticut

Annual Report of Long-Term Care Facility CSP-12 Rev. 10/2005

Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties*

Newfield Rest Home, Inc.	-			License No.	· .	Report for Year Ended	ear Ended		Dogo	
Newneld Kest Home, Inc.					•				T AND	of
				1845		9/30/2015			. 5	
	-	Salary Paid	1						77	10
				Fringe Benefits					•	
			Decidential	and/or Other		Total			Total	
Name	CCNH	RHINS	Care Home	(describe fully)	Full Description of Services Rendered	Hours Worked	Claimed on Page 10	Name and Address of All Other Employment**	Hours	Compensation
Section III - Administrators***									MOINCH	Necessed
			1							
Paul Hotkowski			51,407	,407 Pension	Administrator	2,080 A2	A2			
	-		-							
										
Section IV - Assistant										
Administrators										
									-	
	1									
	_									
						 				
										•

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

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

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

Annual Report of Long-Term Care Facility

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.		Report for Y		Page	of
Newfield Rest Home, Inc.	184	15	9/30/2015		13	37
			Total Cost	and Hours		
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
*B. Direct care consultants paid on a fee						
for service basis in lieu of salary						
(For all such services complete Schedule B1)	1					
1. Dietitian						
2. Dentist						
3. Pharmacist						
4. Podiatrist		nanyanyan and Kananana				
5. Physical Therapy						
a. Resident Care						
b. Other						<u> </u>
6. Social Worker	· · · · · · · · · · · · · · · · · · ·					
7. Recreation Worker					i e	
8. Physicians						
a. Medical Director (entire facility)						
b. Utilization Review						
(Title 18 and 19 only) monthly meeting					<u> </u>	
c. Resident Care**						
d. Administrative Services facility 1. Infection Control Committee						
(Quarterly meetings)						
Pharmaceutical Committee						
(Quarterly meetings)						
3. Staff Development Committee						ļ
(Once annually) e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care			<u> </u>			
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care					<u> </u>	<u> </u>
2. Administrative***		v napodorodnika programa v napodorodnika progr	m California National California (National California (Nationa (Natio			
b. LPN						
1. Direct Care				<u> </u>		
2. Administrative***		ļ <u></u>	ļ <u> </u>	<u> </u>		
c. Aides	ļ	<u> </u>				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries			M-12 and supported	<u></u>		

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

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

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

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

Name of Facility Newfield Rest Home, Inc.	License No. 1845		Report for 9/30/2015	Year Ended	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related* Operato Yes	* to Owners, rs, Officers No		nation of Re	
		0	0			
		0	0		****	
		0	0			
	·	0	0			
		0	0	****	*****	
		0	0		*****	
		0	0			
		0	0		,,,,,,,	
		0	0			
		0	0	-3111		
·		0	0			
		0	0			
		0	0			
		0	0	****		
		0	0			
		0	0			
		0	0			
		0	0			
		- 0	0			
		0	0			
		0	0			
		0	0			

^{*} Use additional sheets if necessary.

^{**} Refer to Page 4 for definition of related.

Annual Report of Long-Term Care Facility

CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.		Report for Y	ear Ended	Page	of
Newfield Rest Home, Inc.	1845		9/30/2015		15	37
						 Residential
Item			Total	CCNH	RHNS	Care Home
			Total	COLUX	Idiro	
T 1 1/1 0 W 10 D C4-						
a. Employee Health & Welfare Benefits 1. Workmen's Compensation		\$	14,823			14,823
		\$	14,625			11,025
2. Disability Insurance3. Unemployment Insurance		\$	6,530			6,530
		\$	14,859			14,859
4. Social Security (F.I.C.A.)		<u>φ</u>	13,597			13,597
5. Health Insurance		φ	13,391			13,377
6. Life Insurance (employees only)		ሰ				
(not-owners and not-operators)		\$	12 110			12 110
7. Pensions (Non-Discriminatory)		\$	13,118			13,118
(not-owners and not-operators)		Φ				Barrier Company
8. Uniform Allowance		\$				
9. Other (Specify)		\$				
See Attached Schedule						
b. Personal Retirement Plans, Pensions, and		\$	BY STATE OF THE ST			
Profit Sharing Plans for Owners and						
Operators (Discriminatory)*						
c. Bad Debts*		\$				
d. Accounting and Auditing	• • • • • • • • • • • • • • • • • • • •	\$	8,615			8,615
e. Legal (Services should be fully described o	n Page 7)	\$	300			300
f. Insurance on Lives of Owners and		\$				
Operators (Specify)*						
g. Office Supplies		\$	799			799
h. Telephone and Cellular Phones						
1. Telephone & Pagers		\$	2,769			2,769
2. Cellular Phones		\$	2,407	1		2,407
i. Appraisal (Specify purpose and		\$				
attach copy)*						
j. Corporation Business Taxes (franchise tax)	\$	375			375
k. Other Taxes (Not related to property - See						
1. Income*	3 / / /	\$				
2. Other (Specify)		\$				
See Attached Schedule		•				
3. Resident Day User Fee		\$			The second secon	
Subtotal		\$				78,193

^{*} 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

Newfield Rest Home, Inc. 9/30/2015

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Residential Care Home
			reserve a serve
	0.0000000000000000000000000000000000000	icas estados estados e	
	des anales de des de virin de des	p. 1800 - 1800 - 18. 18. 19. 19.	
		(1) (2) (A) (1)	
			, and the second second
	2 515 5 5 5 6 6 6 6		
Total	\$ -	\$ -	\$ -

Schedule of Other Taxes

Description	CCNH	RHNS	Residential Care Home
	20 (0.00)		
Total	\$ -	\$ -	\$ -

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

Name of Facility	License No.	Report for	Year Ended	Page	of
Newfield Rest Home, Inc.	1845	9/30/2015		16	37
					Residential
Item		Total	CCNH	RHNS	Care Home
Subtotal	s Brought Forward:	78,193			78,193
Travel and Entertainment	<u> </u>				
Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
Gifts to Staff and Residents	\$	356			356
4. Employee Travel	\$	3			
5. Education Expenses Related to Seminars an	d Conventions \$				
6. Automobile Expense (not purchase or depre	eciation) \$	4,576			4,576
7. Other (Specify)	\$				
See Attached Schedule					
m. Other Administrative and General Expenses					
 Advertising Help Wanted (all such expense. 					
2. Advertising Telephone Directory (all such e					
 Advertising Other (Specify)*** 	\$				
See Attached Schedule					
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service		92200000000000000000000000000000000000	#00-1/12-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-		
directly and not by contract or fee for service					
7. Postage	\$				390
* 8. Dues and Membership Fees to Professional	\$				
Associations (Specify)					
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-A					
9. Subscriptions	\$				
10. Contributions***	\$	1			1
See Attached Schedule					
11. Services Provided by Contract (Specify and	_				
Schedule C-2, Page 21 for each firm or indi					
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>)	\$	4,995			4,995
See Attached Schedule					
C-14 Total Administrative & General Expenditures	\$	88,511			88,511

^{*} 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	Residential Care Home
	75070000000		000000000000000000000000000000000000000
	The control of the control		Vision in the second second
	Sea Blacker	0.000/00/00/00/00	\$14000 (1500)
	VS PROPERTY.	steerstand constructed	ogenbiskiskures.
		数据的数据的是	
		AND CONTROL OF THE	1557/45554554534
	(25/49/98) (35)		1620 1271 1281 1281
Total Other Travel and Entertainment	S	\$	\$ 1000000000000000000000000000000000000

Schedule of Other Advertising

			Residential
Description	CCNII	RHNS	Care Home
	25/25/2005/05	1052 (VO) (16 (V	ASSESS SACRESS
		9/19/19/00/19:02	\$\$\$\$\$\$\$\$\$\$\$\$\$\$
		200000000000000000000000000000000000000	daylar independent
Total Other Advertising	\$	\$	\$

Schedule of Dues

			Residential
Description	CCNH	RHNS	Care Home
	\$4500 BE		
	ASSESSED US		
	1,000,000,000,000	3038331506	NOTE: SE
	19520100/00/4004		Ministration (
	1201141211221122	900000000000000000000000000000000000000	MANAGES .
		50.000000000000000000000000000000000000	.00210f02040f00
	CHECKER PRODUCES		1905/8445/034
		201000000000000000000000000000000000000	
	450000000000000000000000000000000000000	Subject the	2/30/10/30 VENES
		10/08/2005/2014	23/20/20/20/20
Total Dues	\$ 10000200	\$ 1000	\$

Schedule of Contributions

			Kesidentiai
Description	CCNH	RHNS	Care Home
PriceRite		Book to the	s 1
		STANCES	
		351000000000000000000000000000000000000	186000000000000000000000000000000000000
Total Contributions	\$ 2	\$	\$ 1

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
PAYCHEX - PAYROLL PROCESSING	SWAND SERVE	\$200 BEES 19	\$ 4,129
LICENSES		1000 MINERS	\$ 400
LATE FEES & PENALTIES			\$ 172
UNALLOWABLE EXPENSE			\$ 172
AMEX ANNUAL MEMBERSHIP	V4.X. 12.X	\$6.58.650.00	\$ 123
	vazastenista	SYNTHERITY	
	104.000.0000	19/02/03/05/05/05	W65456 (684.00)
	0.0000000000000000000000000000000000000	43/14/2014/4/2014	1000.7010954693
	A 150 TA 185 (1)	Systematic Nation	Maria de la composición
	N. 200 (100 (100 (100 (100 (100 (100 (100		
	NVEAUCED/SEESIN		150000000000000000000000000000000000000
Total Other Administrative and General	\$	s -	\$ 4,995

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Newfield Rest Home, Inc.	License No. 1845	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 #

^{*} 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)

		Not	e oi	n Page 5)				
Nar	ne of Facility	Lie	cens	e No.	Report for Y	ear Ended	Page	of
Nev	vfield Rest Home, Inc.			1845	9/30/201:	5	18	37
							Resident	ial Care
	Item			Total	CCNH	RHNS	Но	me
2.	Dietary							
	a. In-House Preparation & Service							
	1. Raw Food		\$	24,324				24,324
	2. Non-Food Supplies		\$	1,546				1,546
	3. Other (Specify)		\$					
	· · · · · · · · · · · · · · · · · · ·							
	b. Purchased Services (by contract other		\$	£432341444443		50 46 0000050500000000000000000000000000000	0	
	than through Management Services)							
	(Complete Schedule C-2 att. Page 21)							
<u> </u>	c. Management Services**		\$					
	d. Other (Specify)		\$					
				7.0				
2E.	Total Dietary Expenditures (2a + b + c + d)		\$	25,870				25,870
							Resident	ial Care
2F.	Dietary Questionnaire			Total	CCNH	RHNS	Ho	me
G.	Resident Meals: Total no. of meals served per	day:*		42				42
H.		O Ye	S	•	No			
I.	Did you receive revenue from employees?	O Ye	s	0	No	If yes, specify amt.		
J.	Where is the revenue received reported in the	Cost R	epor	t? (Page/Line	Item)			
	Is cost of meals provided to persons other					T.C		
K.	· · · · · · · · · · · · · · · · · · ·	O Ye	S	•	No	If yes, specify		
	Members, Guests) included in 2E?					cost.		
L.	<u>. </u>	O Ye	s	•	No	If yes, specify amt.		
M.	Where is the revenue received reported in the	Cost R	epor	t? (Page/Line	Item)			
	Is cost of food (other than meals, e.g.,							
N.	snacks at monthly staff meetings, board	O Ye	a	•	No	If yes, specify		
1, 1,	meetings) provided to employees included	0 10	3	•	140	cost.		
	in 2E?							
o.	Is any revenue collected from employees?	O Ye	S	•	No	If yes, specify amt.		
P.	Where is the revenue received reported in the	Cost Re	epor	t? (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		No.	Report for Y		Page	of
New	field Rest Home, Inc.		1845	9/30/2015		19	37
						Residen	tial Care
	Item		Total	CCNH	RHNS	Но	ome
3.	Laundry						
	a. In-House Processing*	Lbs.					
	1. Bed linens, cubicle curtains, draperies,						
ļ	gowns and other resident care items	Amt. \$	48				48
	washed, ironed, and/or processed.***						
	2. Employee items including uniforms,	Lbs.					
	gowns, etc. washed, ironed and/or					ļ	
	processed.***	Amt. \$					
					 		
İ	Personal clothing of residents	Lbs.					
	washed, ironed, and/or processed.***	Amt. \$					
	4. Repair and/or purchase of linens.***	Lbs.					
		Amt. \$					
	b. Purchased Services (by contract other	\$			<u> </u>		
	than through Management Services)						
	(Complete Schedule C-2 att. Page 21)				100000000000000000000000000000000000000		
	c. Management Services**	\$	KATSHADAYA MADARA KATA			100000000000000000000000000000000000000	
	d. Other (Specify)	\$	493				493
	Laundry supplies - detergent, bleach, softner, e	etc.					
3E.	Total Laundry Expenditures $(3a+b+c+d)$	\$	541				541
3F.	Laundry Questionnaire						
C		Yes	<u> </u>	No	If yes,		
G.	Is cost of employee laundry included in 3E? O	1 62		ואט	specify cost.		
Н.	Did you receive revenue from employees?	Yes	•	No	If yes,		
11.					specify amt.		
I.	Where is the revenue received reported in the Cost	Report?		(Page/Line	e Item)		
J.	Is Cost of laundry provided to persons other	Yes	0	No	If yes,		
۱,۰	than employees or residents included in 3E?	103			specify cost.		
K.	Did you receive revenue from these people? O	Yes	· · · · ·	No	If yes,		
L	1 1				specify amt.		
L.	Where is the revenue received reported in the Cost	Report?		(Page/Line	tem)	-	

^{*} 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	Ren	ort for Year E	Indad		
Newfield Rest Home, Inc.	1845	Cp	9/30/2015	mueu	Page	of
	1043	<u>[</u>	9/30/2013		20	37
				1		
Item			Total	CONTI	Divis	Residential
4. Housekeeping	Sq. Ft. Serviced		10141	CCNH	RHNS	Care Home
a. In-House Care	by Personnel	1	ł		ļ	
1. Supplies - Cleaning (Mops,	Amt.	\$	1,455			
pails, brooms, etc.)	/ mm.	Ψ	1,433			1,455
b. Purchased Services (by contract other	Sq. Ft. Serviced					
than through Management Services)	by Personnel	ŀ	ł		ı	
(Complete Schedule C-2 att.	Amt.	\$				
Page 21)]		J	ļ		
c. Management Services*		\$				
d. Other (Specify)		\$	428		· · · · · · · · · · · · · · · · · · ·	428
Housekeeping supplies- air freshne	r, gloves, clea	ning	ragacini (s			420
4E. Total Housekeeping Expenditures (4a+	b+c+d)	\$	1,883		<u> </u>	1,883
5. Resident Care (Supplies)**						1,003
a. Prescription Drugs***						
1. Own Pharmacy		\$				
2. Purchased from		\$				
b. Medicine Cabinet Drugs		\$	The second secon			
c. Medical and Therapeutic Supplies		\$				
d. Ambulance/Limousine***		\$				
e. Oxygen						
1. For Emergency Use		\$				
2. Other***		\$				
f. X-rays and Related Radiological		\$				
Procedures***	· · · · · · · · · · · · · · · · · · ·					
g. Dental (Not dentists who should be incl	uded under	\$				
salaries or fees)						
h. Laboratory***	<u> </u>	\$				
i. Recreationj. Other (Specify)****		\$	1,864			1,864
(1 3)		\$	60			60
See Attached Schedule K. Total Resident Care Expenditures (5a - 5j						
* Schedule C-1, Page 17 must be fully completed or the		\$	1,924			1,924

^{*} 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	Reside Care	
Description Other resident care supplies-bandaides, antibacterial soap, wipes Bingo candy prizes			\$	54
			\$	7
Biligo dallo) praeso				
			2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
Total Other Resident Care	\$ -	\$ -	\$	60

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 10/2001

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

	-									
Name of Facility Newfield Rest Home, Inc.				License No. 1845	Report for Year Ended 9/30/2015	70			₀ -	of
									77	7
		Related ** to Owners,	to Owners,							·
		Operators, Officers	Officers				Fotal Cost	Total Cost/Page Ref. ***		
Name of Individual or Company	Address	Yes	°N,	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	Residential] .
		0	0					Care House	20	Tille
		0	0						<u> </u>	Ť
		0	0						1	<u> </u>
		0	0							T -
		0	0						1	T-
		0	0						+	~ -
		0	0						1	Τ-
		0	0						1	.
		0	0							
		0	0						1	T
		0	0							T-
		0	0			 			1	-
		0	0			 			1	
		0	0							7

^{*} List all contracted services over \$10,000. Use additional sheets if necessary.

^{**} Refer to Page 4 for definition of related.

^{***} Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Ye	ear Ended		<i>0</i> -	of
Newfield Rest Home, Inc.	1845	9/30/2015		<u> </u>		37
					Residential	Care
Item		Total	CCNH	RHNS	Home	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance						1,862
b. Heat						5,669
c. Light & Power	•		· · · · · · · · · · · · · · · · · · ·			5,182
d. Water	9			ļ	2	2,408
e. Equipment Lease (Provide detail on p						
f. Other (itemize)	\$	1,248				1,248
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a-	6f) \$	31,368		<u> </u>	31	1,368
7. Depreciation (complete schedule page 23						
a. Land Improvements			,			
b. Building & Building Improvements				-		
c. Non-Movable Equipment						
d. Movable Equipment		7,128				7,128
*7e. Total Depreciation Costs (7a+b+c+d)	7,128				7,128
8. Amortization (Complete att. Schedule Pa	ge 24*)					
a. Organization Expense		B				
b. Mortgage Expense		<u> </u>			<u> </u>	
c. Leasehold Improvements		2,859				2,859
d. Other (Specify)		ß				
*8e. Total Amortization Costs (8a+b+c+c	l) :	2,859				2,859
9. Rental payments on leased real property						
real estate taxes included in item 10b		\$ 2,929			_	2,929
10. Property Taxes			<u> </u>			
a. Real estate taxes paid by owner		\$ 10,101			1	0,101
b. Real estate taxes paid by lessor		\$				
c. Personal property taxes		\$ 1,272	<u> </u>	<u> </u>		1,272
11. Total Property Expenses (7e + 8e + 9 +	10)	\$ 24,289		<u> </u>	2	4,289

^{*} 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	Residential Care Home
Minor Equipment - garment racks, tool set, organizer, hampers, towel dis	pensers, ect		\$ 1,248
	(1) (1) (3) (2) (2) (3) (3)		
		(3-12) 100 (3-12)	
	9 (9 3 40 %) (9 34)		
	(80)		
Total Other Repairs and Maintenance	\$ -	\$ -	\$ 1,248

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-23 Rev. 10/2006

Depreciation Schedule

			nebreci	Depreciation Schedule	annar					
Name of Facility		1	License No.	1		Report for Year Ended	nded		Page	jo
Newfield Rest Home, Inc.			1845			9/30/2015			23	37
			Historical			Accumulated				
			Cost	Less		Depreciation to	Method of			
			Exclusive of	Salvage	Cost to Be	Beginning of		Usefui	Depreciation	
Property Item		•	Land	Value	Depreciated	Year's Operations	Ι	Life	for This Year	Totals
A. Land Improvements									<u>motore</u>	
1. Acquired prior to this report period									Alesmo.	
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	edule)									
A-4. Subtotal		1000								
B. Building and Building Improvements										
1. Acquired prior to this report period										
2. Disposals (attach schedule)									Contacto	
3. Acquired during this report period (attach schedule)	edule)									
C. Non-Movable Equipment										
1. Acquired prior to this report period		-	10,573		10,573	10,573	SL	Various		
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	edule)									
C-4. Subtotal										
	oncoline of									
15 4 mileage Logbook		Date of	Historical			Accumulated				
maintained?		Acquisition	Cost	Less		Depreciation to	Method of			
			Exclusive of	Salvage	Cost to Be	Beginning of	Computing	Useful	Depreciation	
Yes	No Month	ıth Year	Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
D. Movable Equipment										
 Motor Vehicles (Specify name, model 										
and year of each vehicle)	×	62015	35 642		35 642		ST	5 veare	7.128	
Ú										
d.										
2. Movable Equipment										
a. Acquired prior to this report period	Var	Var	45,037		45,037	45,037	SL	Various		
b. Disposals (attach schedule)										
c. Acquired during this report period										
(attach schedule)										
D-3. Subtotal										7,128
E. Total Depreciation										7,128

Newfield Rest Home, Inc. 9/30/2015

Schedule of Land Improvements Acquired during this report period

	··		Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:			1	
Sanda de asola esta A		SWEET TO SEE	visioni di di	15/15/13/14/04
AR POR VAN HER SERVE		3384 K 40 B	1945 55 55 65 15	gravatori di
		1818/9810/9810/981	1515/00/68 5	AND CONTRACTOR
		(285 050 000 252)	0.000,000,000,000	
1987-1987-1987-1987-1987-1987-1987-1987-		000000000000000000000000000000000000000	339004300013501	V6 15 150 15
		102012300011644	10000000000000000000000000000000000000	26175019181818181
Total additions for La	and Improvements	\$ -	700 05 05 05	\$
Deletions:				
				essuara passo Assua
			2050,005,005,000,00	
		\$ 000 AND SERVICE.	1997 (1997)	
		Veri 15 15 14 15 15	\$35.75.95.05.05.05.05.05.05.05.05.05.05.05.05.05	
Value sea southern season as		10.53.182.083.186.0	38506/388399A5	150000000000000000000000000000000000000
l'otal deletions for La	and Improvements	\$		\$ -

^{*}Ties to Page 23, Line A3

Schedule of Building Improvements Acquired during this report period

	to remember 12 days of the period		Uscful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:			1	
		Sid Equipment (Committee)	(1,000,000,000,000,000,000,000,000,000,0	
		Estra variante la como		
		2.000.400.000.000.0	0.0000000000000000000000000000000000000	
100 miles (100 miles (N. 654-161.081.844		
Cotal additions for Buildin	ng Improvements	\$ -	V60.08(6).686	\$
Deletions:				
			900000000000000000000000000000000000000	
		100000000000000000000000000000000000000		
		469000000000000000000000000000000000000	12 (2 million and 12 million	00969 (600 L000 (611.03)
Antonio de Santa de Carlos			177-1971-050-7649-7650-76	1.02.0 (1.05.1.02.3.10.2.3.1.1.1.
		200700000		
Cotal deletions for Buildin	ng Improvements	\$ -		s -

^{*}Ties to Page 23, Line B3

Schedule of Non-Movable Equipment Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				1
		000000000000000000000000000000000000000	2000,000,000	
		\$160 min Karake	Andrew Aufter Section	vicinistrais conv.
200000000000000000000000000000000000000			1838	produkteti artik italia
		305000000000000000000000000000000000000		
Total additions for	Non-Movable Equipment	\$ -	5.087.087.085	\$ -
Deletions:				
150, 60,000 (10,000)		transmission.		A15,000 (50) (50 K
		0.8000000000000000000000000000000000000	25.330.000.000.000.000.000.000.000.000.00	160 (A. 161 (A. 161 (A.
405 AV 92 (5.6)			17/18/10/19/19/19/19/19/19/19/19/19/19/19/19/19/	
			707000000000000000000000000000000000000	
		45081925269	500/01/01/01/01/01	7.7 83 937 939 0
Total deletions for	Non-Moyable Equipment	\$		\$ -
				

^{*}Ties to Page 23, Line C3

^{**}Ties to Page 23, Line A2

^{**}Ties to Page 23, Line B2

^{**}Ties to Page 23, Line C2

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
			14 (California)	WWW.035000000000000000000000000000000000
		REPRESENTATION OF THE PROPERTY	200000000000000000000000000000000000000	AMMERICA
		es describer de la la la la la la la la la la la la la		
		verbere beschen eine besch	erivisi avaida svar	
		110000000000000000000000000000000000000		
rotal additions for	Movable Equipment	\$ -	ALMANDAR MIRUSA	\$,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Deletions:				
				16.000/2016/2016
		Society is	A STATE OF THE STA	7. 60.00 (3.5.70)
AND SECTION OF SECTION		THE PROPERTY OF		\$/(\$Christian Legisla)
SAN CONTRACTOR MANAGEMENT		01/20/05/40/05	331000000000000000000000000000000000000	50000000000000000000000000000000000000
				nyarahan manaka
		Dich Media di pangisa sere	ndo várioten (todos)	ephosis and standard and
l'otal deletions for	Movable Equipment	\$ -		\$

^{*}Ties to Page 23, Line D2c

Schedule of Leasehold Improvements Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
3/1/2015	Remodeling	\$ 3,550	5	\$ 710
3/1/2015	Bathroom Remodeling	\$ 6,656	5	\$ 1,331
			The state of the s	
9400 BENEFASSON (1)			188100 18810 1881	
		elis des distribuidad	Surgaries as a surge	07/54/35/05/05/
Total additions for	Leasehold Improvement	\$ 10,206	19.00	\$ 2,041
Deletions:				
		entantanto ala ta		50000 problems (1951)
			510 /680 (ED 005) (A):	
		350,000,000,000,000		A.G. B. B. C.
AD PROPERTY OF A SECONDARY		60.686.666	elección de mala elec	A SSACTORES (SE
		STATE OF THE		and more
Yassansa yasa sanas		3.746.36.76.73		1641086.00088
Total deletions for	Leaschold Improvement	\$ -	Access to the second	\$

^{*}Ties to Page 24, Line C3

^{**}Ties to Page 23, Line D2h

^{**}Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility CSP-24 Rev. 10/2006 State of Connecticut

Amortization Schedule*

Nar	Name of Facility			License No.		Report for Year Ended	r Ended		Page	of
Se	Newfield Rest Home, Inc.			1845	15	9/30/2015	i		24	37
						Accumulated				
		Dat	Date of			Amort. to				
		Acqui	Acquisition			Beginning of	Basis for			
				Length of	Cost to Be	Year's	Computing	Rate	Rate Amortization	
	Item	Month	Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
Ą.	Organization Expense									
	1. Oranzational costs	4		97 5 years	1,875	1.875	SL			
	2.									
<u> </u>	3.									
A-4	A-4. Subtotal									
B.	Mortgage Expense									
	1,									
	2,									
	3.									
B-4.	. Subtotal									
ن	Leasehold Improvements and Other									
	1. Acquired prior to this report period	Var	Var	Var	140,158	137,106 SL	SL		818	
	2. Disposals (attach schedule)									
	3. Acquired during this report period									
	(attach schedule)				10,206				2.041	
C-4	C-4. Subtotal									2.859
<u>.</u>	Total Amortization									2,859

* 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; ORC. Remaining Life of Lease; ORD. Actual Life if owned by Related Party.

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

Name of Facility Newfield Rest Home, Inc.	License No. 1845	Report for Year En	ded		Page of 25 37

11. Property Questionnaire Part A					
Is the property either owned by the	ne Facility	O Yes	0		If "Yes," complete Part B.
or leased from a Related Party?*				NO	If "No," complete Part C.
*If any owner or operator of this fa	cility is related by fami	ly, marriage, ownership, abi	lity to control or		
business association to any person a related party transaction.	or organization from w	nom oundings are leased, in	en it is considered		
Description		Total			
Date Land Purchased					
2. Date Structure Completed	a of Dayshaga	04/25/97			
 If NOT Original Owner, Date Date of Initial Licensure 	e of Purchase	04/25/97			
5. Total Licensed Bed Capacity		14			
Square Footage					
7. Acquisition Cost					
a. Land b. Building					
Part B - Owner and Related Pa	rties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing	ii tros	, , , , , , , , , , , , , , , , , , , ,	8.8	0.0	
a. Type of Financing (e.g., f	ixed, variable)				
b. Date Mortgage Obtained					
c. Interest Rate for the Cost d. Term of Mortgage (numb					
e. Amount of Principal Borr					
f. Principal balance outstand					
Complete if Mortgage was l					
During Current Cost Yo		and the second second			
g. Type of Financing (e.g., f	ixed, variable)				
h. Date of Refinancing i. New Interest Rate	-av-		<u> </u>		
j. Term of Mortgage (numb	er of years)				
k. Amount of Principal Born	owed				
Principal Outstanding on			<u> </u>		
Part C - Arms-Length Leas		rty Improvements Only Property Leased	y Dota of Lease	Tarm of Lagra	Annual Amount of Lease
Name and Address of Lesso	or	Property Leased	Date of Lease	TOTH OF LOAS	Annual Amount of Dease
			-		
			,		
				<u> </u>	

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

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

Name of Facility	License No.		Report for Ye	ear Ended		Page of
Newfield Rest Home, Inc.	1845		9/30/2015			26 37
						Residential Care
	em	···	Total	CCNH	RHNS	Home
12. Interest						
A. Building, Land Impro Equipment	ovement & Non-Movab	ole				
1. First Mortgage		\$				
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage		\$				
Name of Lender		Rate				
Address of Lender		_l.	10.00			
3. Third Mortgage		\$				
Name of Lender		Rate				
Address of Lender		l			and a	
4. Fourth Mortgage		\$				
Name of Lender		Rate				
Address of Lender		<u></u>				
B. CHEFA Loan Informa	ntion					
1. Original Loan Amo	ount	\$				
2. Loan Origination D	Pate					
3. Interest Rate %						
4. Term						
5. CHEFA Interest Ex	rpense					
12 B7. Total Building Interest Ex	cpense (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 Y	ear Ended		Page of
Newfield Rest Home, Inc.	1845		9/30/2015			27 37
						Residential
Iter	m		Total	CCNH	RHNS	Care Home
	Subtotals Bro	ught Forward:				
12. C. Movable Equipment						
1. Automotive Equipme	nt	\$				
A. Item	Rate	Amount				
Y 1						
Lender						
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Y 3		<u> </u>				
Lender						
Address of Lender	·····					
Address of Lender						
12. C. 3. Total Movable Equip	ment Interest					
Expense $(C1 + 2)$		\$				
12. D. Other Interest Expense (Specify)	\$	1,280		Territory connects to a state of the state o	1,280
Interest on auto						
						4.500
13. Total All Interest Expense (1	12B7 + 12C3 + 12D)) \$	1,280			1,280
14. Insurance		•	7.540			7.540
a. Insurance on Property (b		\$				7,548 1,457
b. Insurance on Automobile	es	\$	1,457	<u></u>		1,437
c. Insurance other than Pro		above)				
Umbrella (<i>Blanket Co</i> Fire and Extended Co		<u> </u>				
3. Other (Specify)	overage	<u> </u>				
3. Other (Specify)		Φ				
14d. Total Insurance Expenditur	res(14a+b+c)	\$	9,005		The second secon	9,005
15. Total All Expenditures (A-1)		\$				378,911

D. Adjustments to Statement of Expenditures

	e of Fa	_		Lie	cense No.	Report for Ye	ar Ended	Page	of
New	ueia K	est H	ome, Inc.	<u>L</u> .	1845	9/30/2015	<u> </u>	28	37
T4	D	т !			Total				
	Page				Amount of			Residen	
		No.	Item Description		Decrease	CCNH	RHNS	Но	me
	10 - 5	<i>alari</i>	es and Wages				0.00		
1.			Outpatient Service Costs	\$					
2.			Salaries not related to Resident Care	\$					
3.			Occupational Therapy	\$					
4.	لـــــــا		Other - See attached Schedule	\$					
	13 - F	rofes	sional Fees						
5.			Resident Care Physicians **	\$					
6.			Occupational Therapy	\$					
7.			Other - See attached Schedule	\$					
Pages	s 15 &	16 -	Administrative and General						
8.			Discriminatory Benefits	\$					
9.			Bad Debts	\$					
10.			Accounting & Legal	\$	***************************************				
11.			Telephone	\$	•				
12.	15	H2	Cellular Telephone	\$	1,687				1,687
13.			Life insurance premiums on the life						
			of Owners, Partners, Operators	\$	A CONTRACTOR OF THE PARTY OF TH		(*************************************	AND TO SERVICE AND THE SERVICE	
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						Maria de la companya
,	l		conferences or seminars outside the						
			continental U.S. Other out-of-state						
			travel in excess of one representative	\$					
17.	16	L6	Automobile Expense (e.g. personal use)	\$	4,576				4,576
18.	-10	1.70	Unallowable Advertising *	\$	4,370				4,370
19.	15	IJ	Income Tax / Corporate Business Tax	\$	125				125
20.	13		Fund Raising / Contributions	\$	123				125
21.			Unallowable Management Fees	\$					
22.			Barber and Beauty	\$					
23.			Other - See attached Schedule	\$					
	10 D	Jatan.	Expenditures	<u> </u>					
	10 - D								
24.			Meals to employees, guests and others	ф.					
<u> </u>	10 7		who are not residents	\$		V (6 - 5 - 04 - 7 - 85 - 7		DAKUS KING PASSANIESK	
	19 - L	aund)	ry Expenditures						
25.			Laundry services to employees, guests						
	20 -		and others who are not residents	\$	S0 - 30 - 32 - 32 - 32 - 32 - 32 - 32 - 3	Harrist Control Contro			, 9075002220000
	20 - H		keeping Expenditures						
26.			Housekeeping services to employees, guests						
			and others who are not residents	_\$					
			Subtotal (Items 1 - 26)	\$	6,388				6,388

^{*} 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	Residential Care Home
			2010 10 Giv		
	100,000,000,00				
10040110000					
Total Othe	r Salaries	Adjustment	\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref Description	CCNH	RHNS	Residential Care Home
2000040000				
			12 St. 12 De 2013	
100000000000000000000000000000000000000				
52.15.65.65				
Total Othe	r Fees Adjustments	\$.	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
2.000				on the second	
0.000			er egende og en integral		
North No.					
9.0050000000000000000000000000000000000			V 20 00 00 00 00 00 00 00 00 00 00 00 00	V Superior Design	
1.15					
5785 1575			100 200 000		
Total Othe	r A&G Ad	ljustments	\$ -	\$	\$ -

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

			D. Adjustments to Stateme						
	e of F			Li	cense No.	Report for '	Year Ended	Page of	f
New	field I	Rest H	lome, Inc.		1845	9/30/2015		29 37	
		1			Total				
	Page				Amount of			Residential Ca	are
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	Home	
ļ			Subtotals Brought Forward	\$	6,388			6,3	88
	20 - 1	Reside	ent Care Supplies***						
27.		<u> </u>	Prescription Drugs	\$					<i>/////////////////////////////////////</i>
28.	<u></u>	ļ	Ambulance/Limousine	\$					
29.		ļ	X-rays, etc	\$					
30.			Laboratory	\$					
31.			Medical Supplies	\$					
32.	ļ		Oxygen (non emergency)	\$					
33.			Occupational Therapy	\$					\neg
34.			Other - See Attached Schedule	\$					
	22 - A	<i>Aaint</i>	enance and Property						
35.			Excess Movable Equipment Depreciation						
			See Attached Schedule	\$					*********
36.	22	7D.2	Depreciation on Unallowable						
			Motor Vehicles	\$	7,128			7,12	28
37.	22	10C.2	Unallowable Property and Real						
			Estate Taxes	\$	750			75	50
38.			Rental of Building Space or Rooms	\$					\dashv
39.			Other - See Attached Schedule	\$				·	\exists
	27 - I								
40.			Mortgage Insurance	\$					220000
41.	27	14B	Property Insurance	\$	1,457			1,45	7
Other	· - Mis	cellar	neous						
42.			Research or Experimental Activities	\$:				0000000
43.			Radio and Television Revenue	\$					_
44.			Vending Machine Revenue	\$					ᅥ
45.			Purchase Discounts and Allowances	\$					ㅓ
46.			Duplications of functions or services	\$					ᆿ
47.			Expenditures made for the protection,						
			enhancement or promotion of the						
			providers interest	\$	**************************************			<u> </u>	S2222
48.			Interest Income on Accounts Rec	\$					\dashv
49.			Other (include personnel and other						
			costs unrelated to resident care) - See						
]	Attached Schedule	\$	344			344	4
Not F	or Pre	ofit Pi	oviders Only	desire				54-	
50.			Building/Non Movable Eq. Depreciation	1					
			Unallowable Building Interest -						
	[See Attached Schedule	\$					
51.	Total .		int of Decrease (Items 1 - 50)	\$	16,067			16,06	7
				- 1	.,			10,00	

^{***} 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.

Newfield Rest Home, Inc. 9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
	News seek				
	CONTRACTOR				
CONTROL OF THE CONTRO	All Company of the Co				
13.73.40.4					
	MARKAN ARKAN				
100 (100 (100)	6000000000				
	78.00 V/2/2/2000 V/2				
Valore as A					
Total Othe	r Ancilları	y Costs	\$ -	\$	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
(19)	100000000000000000000000000000000000000				
- 10 VEV. 20 SERVE					
	180000000000000000000000000000000000000				
S. 10 . 10 . 1	ASSESSED AND		10 (A) (C) (F) (E)		
					07.00 (A) (C) (B)
4.441.554.0002.55					
					gerieg Vegerleg Veleiner.
				and the state of the state of	
Total Exce	ss Movabl	e Equipment Depreciation	\$.	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
	7 07 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				
	500000000				
15000000000			2002 SS (ESVE) SS	go go di dia go di	
050000000000000000000000000000000000000	1965 (1965)				
(311-315-315-31					
1000000000000			100000000000000000000000000000000000000		
	6.0.00				
24/10/25/09	100000000000000000000000000000000000000				\$ \$7.00 \$7.5
Version land	0.0000000000000000000000000000000000000				Managada a ca
Total Othe	r Property	Adjustments	\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
16	M13	Late fees			\$ 172
16	M13	Unallowable costs			172
16	10	Contribution			\$ 1
				194 A Secretario Secretario (1941)	
30 (20 (20 (20 (20 (20 (20 (20 (20 (20 (2			According to the second	: 150 SELVEN SELVEN	6.000000000000000000000000000000000000
0.000	\$200.00				5.45.35.05.35.35
100 VIII. VIII. VIII. VIII. VIII. VIII. VIII. VIII. VIII. VIII. VIII. VIII. VIII. VIII. VIII. VIII. VIII. VIII					
(5) (36) (3) (3)			Character with the control	21 Sept. (1995) 1995 (1995) 1995	Course Observed Automobiles
Total Other	r Adjustm	ents	\$ -	\$ -	\$ 344

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
412444					
	NEC SERVICES		100000000000000000000000000000000000000		
10.000000					B 49 (8 3 7 4)
	372556 (1000)		1000 348 0725 3807 38	103/00/00/00	3.490.55.000.000
	Activities of cold				
A STAR STARS	10.00		6.50 (88) (87) (88) (87)		80.00.000.000.000
			1,500,000,000,000		
			1000 150 (42) 150 (4)		8 0000000000000000000000000000000000000
11:500000000000000000000000000000000000			100 35 75 175 35	Language of the	55 (84 (55 (55 (5))
Total Unal	lowable Bı	illding Interest	\$ -	\$	\$

F. Statement of Revenue

Name of Facility Newfield Rest Home. Inc. License No. 1845		Report for Y 9/30/2015	ear Ended		Page of 30 37
Newfield Rest Home, Inc. 1845		9/30/2013			
Item		Total	CCNH	RHNS	Residential Care Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (CT only)	\$	439,028			439,028
b. Medicaid Room and Board Contractual Allowance **	\$	155,020			
2. a. Medicaid (All other states)	\$				
b. Other States Room and Board Contractual Allowance **	- \$			-	
3. a. Medicare Residents (all inclusive)	\$				
b. Medicare Room and Board Contractual Allowance **	\$				
4. a. Private-Pay Residents and Other	\$				
b. Private-Pay Room and Board Contractual Allowance **	\$				0.16-118-2-1
II. Other Resident Revenue					
a. Prescription Drugs - Medicare	\$				
b. Prescription Drugs - Medicare Contractual Allowance **	\$			<u> </u>	
c. Prescription Drugs - Non-Medicare	\$				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$				
a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				117-17-1
3. a. Physical Therapy - Medicare	\$				
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$				
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$				
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other (Specify) - Medicare	\$				
	\$				
b. Other (Specify) - Non-Medicare	Φ.	420.000		<u>-</u>	420.028
III. Total Resident Revenue (Section I. thru Section II.)	\$	439,028			439,028
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$			ļ	
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
Rental of Television and Cable Services	\$				
5. Interest Income (Specify)	\$				
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (Specify)	\$	8,962			8,962
V. Total Other Revenue (1 thru 8)	\$	8,962			8,962
VI. Total All Revenue (III +V)	\$	447,990			447,990
		•			

^{*} 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	Residential Care Home
SECTION OF		2000/25/2000/01/26/2001/03	CHIRD	Care nome
			100000000000000000000000000000000000000	
1000 miles (1000)				
deciminate and				
		\$1.64 GD NW SW		
		ve 35, 350 (Co.)597		
Total Othe	r Resident Revenue - Medicare	\$	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

B. D.A.D. J. J.			Residential
Page Ref Description	CCNH	RHNS	Care Home
	200 - 100 -		110000000000000000000000000000000000000
	100000000000000000000000000000000000000		
	00.000.000.00	60.000.000.000.000	100 000 000
	000000000000000000000000000000000000000		
	10.35	2 (2) (6) (4) (6)	0.0000000000000000000000000000000000000
Total Other Resident Revenue	\$	\$ -	\$ 2000000000000000000000000000000000000

Interest Income

Account

Page Ref Account	Balance	CCNII	RHNS	Residential Care Home
	(\$10.000) \$2200\$\$ (a.e. to		STATE OF STA	9.4 (93) (49) (45) (45)
	944 CO 100 CO 10	120		
		Valuacione (Al Valuacione)		
Total Interest Income	A STATE OF THE PROPERTY.	\$	\$ -	s .

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
30IV8	Gain on Sale of Vehicle			\$ 8,962
21/20/10/20/10 1/20/20/20/20/20/20/20/20/20/20/20/20/20/		Agricultura de Companyo de la		50.000 000 001.000
			(51.55.359.35).16	60.55.55.55.55.00
			SOUTH OF THE SECOND	
1-1-1-10 (A) (A)			161 (0) (61) (62) (62)	10.05 (3.04)
540000.5				(3.450.757.657.657
3000 SMR		tree receivement car	oganidativija, valonija,	les per la confestione de contr
			V. 4	Service Control of Service (V
		200 (200 (20) (20)		Asia Control (Control
				1.0000000000000000000000000000000000000
Total Othe	r Revenue	\$ -	\$ -	\$ 8,962

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Newfield Rest Home, Inc.	1845	9/30/2015	31	37
	Account		Am	ount
Assets				
A. Current Assets				42.070
1. Cash (on hand and in ba		6 2 12 14	\$	43,868
2. Resident Accounts Rece			\$ \$	24,734
3. Other Accounts Receival	ole (Excluding Owners of	or Related Parties)	\$	786
4 Inventories			\$	4,148
5. Prepaid Expenses		4 1 4 0	Φ	4,140
a. Prepaid Insurance		4,148	-	
b			-	
с				
d.			\$	
6. Interest Receivable	ut Danaissahla		\$	
7. Medicare Final Settleme			\$	
8. Other Current Assets (ite	mize)		Φ	
A O Total Comment Aggets (Lines	A 1 +lany (2)		\$	73,536
A-9. Total Current Assets (Lines	AI uuu o)		Ψ	75,550
B. Fixed Assets			\$	
1. Land	*Historical Cost	·	\$	
2. Land Improvements	Accum. Deprecia	tion Net	"	
3. Buildings	*Historical Cost	tion ivet	\$	
3. Bundings	Accum. Deprecia	tion Net	Ψ	
4. Leasehold Improvements		150,365	\$	10,400
4. Leasehold improvement	Accum. Deprecia		ľ	,,,,,,,
5. Non-Movable Equipmen		10,573	\$	
5. Non-Movable Equipmen	Accum. Deprecia		*	
6. Movable Equipment	*Historical Cost	45,037	\$	0
o. Wovable Equipment	Accum. Deprecia		ľ	_
7. Motor Vehicles	*Historical Cost	35,642	\$	28,514
7. Wiotor venicles	Accum. Deprecia			
8. Minor Equipment-Not D		7,120 1100	\$	
9. Other Fixed Assets (<i>item</i>			\$	
9. Other Pixed Assets (nem	1146)		T T	
B-10. Total Fixed Assets (Lin	es B1 thru 9)		\$	38,914

^{*} 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)

Nam	e of Facility		License No.	Report for Year Ended		Page	О	f
New	field Rest Home,	, Inc.	1845	9/30/2015		32	3′	7
			Account			Am	ount	
				Total Brought Forwar	d: \$		112,45	51
C.	Leasehold or lik	ke property recor	ded for Equity Purpos	ses.				
	1. Land				\$			
	2. Land Impro	vements	*Historical Cost					
			Accum. Depreciati	on Net	\$			
	3. Buildings		*Historical Cost		١.			
			Accum. Depreciati	on Net	\$			
	4. Non-Movab	le Equipment	*Historical Cost		1.			
			Accum. Depreciati	on Net	\$			
	5. Movable Eq	uipment	*Historical Cost					
			Accum. Depreciati	on Net	\$			
	6. Motor Vehic	cles	*Historical Cost					
			Accum. Depreciati	on Net	\$			
		oment-Not Depre			\$			
C-8		d or Like Proper	ties (C1 thru 7)		\$			_
D.	Investment and							
	1. Deferred De				\$			
	2. Escrow Dep				\$			
	3. Organization	n Expense	*Historical Cost	1,875				
			Accum. Depreciati	on 1,875 Net	\$			
		urchased Only)			\$			
	5. Investments	Related to Resid	lent Care (itemize)		\$			286)B
					_			
<u></u>					4			
			Parties (itemize)		\$			
	Name	e and Address	Amount	Loan Date	_			
	7: Othor Andet	o (it invitates)			· d·			
	7. Other Assets	s (nemize)			ů			
	t				-			
					\dashv			
D º	Total Instantes	ute and Other A	sets (Lines D1 thru 7	7)	\$			
	Total All Assets			")	\$		112,45	 . 1
レータ.	A OTHE ATT ASSETS	(PHICS MY T D)	0 1 (0 1 (10)		1 _D		112,43	11

^{*} 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 Fac			License No.	Report for Year	Ended	Page	of
Newfield Re	est Ho	me, Inc.	1845	9/30/2015		33	37
			Account			Amo	ount
Liabilities							
A.	Cu	rrent Liabilities					
	1.	Trade Accounts Payable			\$		32,885
	2.	Notes Payable (itemize)			\$	(6)	
					<u>-</u>		
		T D 11 C D 1	1/0 / "	\ (\)	ф.		
	3.	Loans Payable for Equipm			Date Due		
		Name of Lender	Purpose	Amount	Date Dile		
					-		
	4.	Accrued Payroll (Exclusive	of Owners and/or	Stockholders only)	\$		3,072
	5.	Accrued Payroll (Owners a	ind/or Stockholders	only)	\$		1,134
	6.	Accrued Payroll Taxes Pay	able		\$		353
	7.	Medicare Final Settlement	Payable		\$		
	8.	Medicare Current Financin	g Payable		\$		
	9.	Mortgage Payable (Curren	t Portion)		\$		
	10.	Interest Payable (Exclusive	of Owner and/or R	Celated Parties)	\$		
	11.	Accrued Income Taxes*			\$		
	12.	Other Current Liabilities (i	temize)		\$		35,005
		Discover	2,	,008 Accrued Corp Tax	250		
		AMEX		474 Due DSS	31,141		
		Capital One Visa		,091.			
		Mastercard		41			
A-13	. To	tal Current Liabilities (Line	es A1 thru 12)		\$	·	72,449

^{*} 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	License No.	Report for Year	Ended	Page 34	of 37
Newfield Rest Home, Inc.	1845	9/30/2015			
A	Account	Total Broug	1.4 72 4.	A	mount 72,449
		72,449			
Liabilities (cont'd)					
B. Long-Term Liabilities	/// · \		\$		16,439
1. Loans Payable-Equipment		A an ayant	Date Due		10,437
Name of Lender	Purpose	Amount	Date Due		
Citizens	Auto				
 Mortgages Payable Loans from Owners or Rel 	· · · · · · · · · · · · · · · · · · ·		\$		(34,920
Name and Address of Lender	Amount	Loan I	Date		
Pual & Donna Hotkowski	(34,920)				
4. Other Long-Term Liabiliti	es (itemize)		, d		
_ 					
<u> </u>					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)		5	\$	(18,48)
C. Total All Liabilities (Lines A-	(13 + B-5)			\$	53,968

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

1	ne of Facility	License No.	Report for Ye	ar Ended	Page)	of
Nev	vfield Rest Home, Inc.	1845	9/30/2015		35		37
A.	Reserves	Account				Amount	
Α.		_			1.		
<u> </u>	Reserve for value of leased	land			\$		
	2. Reserve for depreciation va	lue of leased build	lings and appurten	ances			
	to be amortized				\$		
	3. Reserve for depreciation va	lue of leased perso	onal property (Equ	ity)	\$		
	4. Reserve for leasehold real p	properties on which	h fair rental value i	s based	\$.,	
	5. Reserve for funds set aside	as donor restricted	l	W1	\$		
	6. Total Reserves				\$		
B.	Net Worth						
	1. Owner's Capital				\$		•
	2. Capital Stock				\$		1,000
	3. Paid-in Surplus				\$		
	4. Treasury Stock				\$		
	5. Cumulated Earnings				\$	(1	1,595)
	6. Gain or Loss for Period	10/1/20	014 thru	9/30/2015	\$	6	9,079
<u>.</u>	7. Total Net Worth				\$	5	8,484
C.	Total Reserves and Net Worth				\$	5	8,484
D.	Total Liabilities, Reserves, and	l Net Worth			\$	11	2,451

H. Changes in Total Net Worth

Name of Facility		License No.	Report for Year	Ended	Page	of
Newfield Rest Home, Inc.		1845	9/30/2015		36	37
Account					Amount	
A.	Balance at End of Prior Period as shown on Report of 09/30/2014			1	\$	20,385
В.	Total Revenue (From Statement of Revenue Page 30)				\$	447,990
C.	Total Expenditures (From Statement of Expenditures Page 27)				\$	378,911
D.	Net Income or Deficit				\$	69,079
E.	Balance			;	\$	89,464
F.	Additions 1. Additional Capital Contributed Reduction prior yr revenue Prior yr adj 2. Other (itemize)	•	(31,146) 165			
F-3.	Total Additions	ns			\$	(30,981)
G.	Deductions Deductions				·	(= -5)
	Drawings of Owners/Operators/Partners (Specify)				\$	
	Name and Address (No., City,	State, Zip)	Title	Amount		
	2. Other Withdrawings (Specify)					
	Purpose		Amou	ınt		
	3. Total Deductions				\$	
H.	Balance at End of Period 09/30/15				\$	58,483

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended Page of					
Newfield Rest Home, Inc.	1845	9/30/2015 37 37					
Check appropriate category							
Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)	☑ Residential Care Home					
P	reparer/Reviewer Certific	ation					
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). Purther, 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 Partiner	Date Signed Q-S-16					
Printed Name of Preparer							
Craig J. Lubitski Consulting LLC Address							
Address		Phone Number					
225 Pitkin Street, East Hartford, CT 06108	•	860-610-9009					