State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2016

Name of Facility (as licensed) Westview Nursing Care & Rehabilitation Center, Inc.		
Address (No. & Street, City, State, Zip Code) 150 Ware Road Dayville, CT 06241		
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
	930-C			07-5078

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	9308		

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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Westview Nursing Care & Rehabilitation Center, Inc.	930-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 Westview Nursing Care & Rehabilitation Center, Inc. [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) David T. Panteleakos			Printed Name (Owner) Herbert Czermak	
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 Westview Nursing Care & Rehabilitation Center, Inc.	Period Covered:		From 10/1/2015	To 9/30/2016
Address of Facility 150 Ware Road Dayville, CT 06241				
Report Prepared By Donna LaHaie	Phone Number 860-774-8574		Date	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-774-8574	9/30/2016	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Westview Nursing Care & Rehabilitation Center, Inc.	150 Ware Road Dayville, CT 06241

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	930-C			07-5078

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.:
David T. Panteleakos	1129

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
Westview Nursing Care & Rehabilitation Ce	930-C	9/30/2016	3A	37

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
Westview Nursing Care & Rehabilitation Center, Inc.	150 Ware Road Dayville CT 06241	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Chaim H. Czermak	1018 New McNeil Avenue, Lawrence, NY 1155	resident/Treasur	200
Marvin Czermak	1049 East 23rd Street, Brooklyn, NY 11210	-President/Secr	100
Maurice Czermak	35 Broadway, Lawrence, NY 11559	Director	50
Isabelle Katz	1 Regent Drive, Lawrence, NY 11559	Director	50
Names of Stockholders Owning at Least 10% of Shares			
Chaim H. Czermak	1018 New McNeil Avenue, Lawrence, NY 1155	resident/Treasur	50
Marvin Czermak	1049 East 23rd Street, Brooklyn, NY 11210	-President/Secr	25
Maurice Czermak	35 Broadway, Lawrence, NY 11559	Director	12.5
Isabelle Katz	1 Regent Drive, Lawrence, NY 11559	Director	12.5

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Westview Nursing Care & Rehabilitation Center, I	930-C	9/30/2016	3B	37

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	%**				
Westview Land Company	Same as Facility	○	⊙		Lessor	Pg. 22/Line 9	840,000	
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Westview Nursing Care & Rehabilitation Cente	930-C	9/30/2016	5	37

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

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

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

1. In the preparation of this Report, were all costs allocated as required? ⊙ 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.

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.

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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
US Bank	○	⊙	Printers/Copiers	12/15/11	60 months	51,411	51,411
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
						Total ***	51,411

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 Marcum LLP	555 Long Wharf Dr. New Haven, CT 06511
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Annual Audit Review, Financial Statements, and Annual Tax Returns	$ 16,423
2		$
3		$
4		$
	Charge for Services Provided	$ 16,423

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

⊙ Yes ○ No — Pg. 15/Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Wiggin & Dana	203-498-4400
2 William G. Reveley & Associates LLC	860-872-0686
3 Sarantopoulos & Sarantopouos	860-774-3913
4	
5	

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

1 One Century Tower, New Haven, CT
2 117 Hartford Pike, Tolland, CT
3 143 School Street, Danielson, CT
4
5

Services Provided by This Firm (*describe fully*)

1	A/R Collections - Legal Advisement/Estate Issues	$ 238
2	Costs associates with patient collections	$ 577
3	A/R Collections - Legal Advisement/Court Docs	$ 400
4		$
5		$
	Charge for Services Provided	$ 1,215

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

⊙ Yes ○ No — Page 15/Line 1e

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Schedule of Resident Statistics

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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	103	103			103	103			103	103		
B. On last day of THIS report period	103	103			103	103			103	103		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	99	99			99	99			96	96		
B. As of midnight of THIS report period	102	102			101	101			102	102		
3. Total Number of Days Care Provided During Period												
A. Medicare	10,199	10,199			7,906	7,906			2,293	2,293		
B. Medicaid (Conn.)	16,943	16,943			12,686	12,686			4,257	4,257		
C. Medicaid (other states)												
D. Private Pay	10,004	10,004			7,200	7,200			2,804	2,804		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	37,146	37,146			27,792	27,792			9,354	9,354		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	91	91			73	73			18	18		
B. Other Bed Reserve Days	62	62			38	38			24	24		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	37,299	37,299			27,903	27,903			9,396	9,396		

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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	26	43		33				
Per Diem Rate								
a. One bed rm.								
b. Two bed rms.	581.98	238.15		340.63		484.00		
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	14,651	14,651		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	61,778	61,778		
D. ***Total Physical Therapy Treatments***	76,429	76,429		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	454	454		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	677	677		
D. ***Total Speech Therapy Treatments***	1,131	1,131		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	2,832	2,832		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	32,868	32,868		
D. ***Total Occupational Therapy Treatments***	35,700	35,700		

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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)	130,714	2,120				
2. Administrator(s) (Complete also Sec. III of Schedule A1)	86,534	2,289				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	573,474	22,090				
5. Dietary Service						
a. Head Dietitian	79,065	2,478				
b. Food Service Supervisor						
c. Dietary Workers	474,132	31,583				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	201,522	14,336				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	100,430	2,164				
b. Other Maintenance Workers	208,861	13,122				
8. Laundry Service						
a. Supervisor	47,231	2,234				
b. Other Laundry Workers	131,165	9,094				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	112,183	2,246				
b. RN						
1. Direct Care	1,025,593	31,709				
2. Administrative**	85,954	2,295				
c. LPN						
1. Direct Care	839,321	32,506				
2. Administrative**						
d. Aides and Attendants	1,898,173	116,258				
e. Physical Therapists	1,060,884	33,304				
f. Speech Therapists	69,673	1,557				
g. Occupational Therapists	556,197	17,762				
h. Recreation Workers	110,301	5,735				
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	185,356	6,790				
n. Marketing	42,012	2,106				
o. Other (Specify)						
See Attached Schedule	269,303	13,880				
A-13. Total Salary Expenditures	8,288,078	367,657				

* 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**
Unit Secretary	$ 84,396	4,281				
Administrative Therapy Assistant	$ 83,471	4,846				
Sports Therapy Administrative Assistant	$ 52,368	2,785				
Admissions Coordinator	$ 49,068	1,968				
Total	$ 269,303	13,880	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

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

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

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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										
Herbert Czermak	130,714				Comptroller	520	A1			
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* **										
David T. Panteleakos	86,534				Administrator	2,289	A2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Westview Nursing Care & Rehabilitation Center, Inc	930-C	9/30/2016	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist	2,750	196				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker	740	9				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	36,000	78				
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)						
Organized Medical Staff	725	12				
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
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						
B-13 Total Fees Paid in Lieu of Salaries	40,215	294				

* 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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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
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Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Jeffrey Howe, MD - Pomfret Street Putnam, CT	Medical Director	○	⊙	
David Wilterdink, MD - Green Hollow Rd. Danielson, CT	Medical Staff	○	⊙	
Joseph Alessandro, MD - Brooklyn, CT	Medical Staff	○	⊙	
Joseph Botta, MD - So. Main Street Putnam, CT	Medical Staff	○	⊙	
Mark Wrabel, Willimantic, CT	Pharmacy Consultant	○	⊙	
Witney Reid, L.C.S.W. - 39 Woodland Dr. Lebanon, CT	Social Services Consultant	○	⊙	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
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		○	○	
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		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
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Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	142,772	142,772		
2. Disability Insurance	$				
3. Unemployment Insurance	$	167,935	167,935		
4. Social Security (F.I.C.A.)	$	622,542	622,542		
5. Health Insurance	$	767,539	767,539		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	25,389	25,389		
7. Pensions (Non-Discriminatory)	$	97,466	97,466		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	14,149	14,149		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)* Deferred Pension	$	10,008	10,008		
c. Bad Debts*	$	6,782	6,782		
d. Accounting and Auditing	$	16,423	16,423		
e. Legal (*Services should be fully described on Page 7)*	$	1,215	1,215		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	39,287	39,287		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	45,509	45,509		
2. Cellular Phones	$	2,993	2,993		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$	250	250		
2. Other (*Specify*)	$	1,223	1,223		
See Attached Schedule					
3. Resident Day User Fee	$	570,146	570,146		
Subtotal	$	2,531,629	2,531,629		

* 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)
Tuition Reimbursement	$ 2,009		
Employee Physicals & Health	$ 5,977		
Flex Spending Insurance Accounts	$ 3,544		
Background Check Fees	$ 2,619		
Total	$ 14,149	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Sales Tax	$ 1,223		
Total	$ 1,223	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Westview Nursing Care & Rehabilitation Center, Inc.	930-C	9/30/2016	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,531,629	2,531,629		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	7,332	7,332		
3. Gifts to Staff and Residents	$	10,957	10,957		
4. Employee Travel	$	6,127	6,127		
5. Education Expenses Related to Seminars and Conventions	$	18,191	18,191		
6. Automobile Expense (*not purchase or depreciation*)	$	10,730	10,730		
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	7,524	7,524		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	61,004	61,004		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$	10,874	10,874		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	6,205	6,205		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	5,757	5,757		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	2,703	2,703		
10. Contributions***	$	25,125	25,125		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	37,375	37,375		
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	175,568	175,568		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,917,100	2,917,100		

* 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)
Community Education & Promotional Advertising	$ 61,004		
Total Other Advertising	$ 61,004	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Membership Fees	$ 1,434		
License Fees	$ 4,323		
Total Dues	$ 5,757	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Various Donations/Contributions	$ 25,125		
Total Contributions	$ 25,125	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Consulting Fees - Administrator Fee for Consulting (Disallowed)	$ 103,042		
Bank Charges & Credit Card Fees	$ 9,333		
Computer Operations Support Fees	$ 43,499		
Unallowable Auto Expense	$ 4,182		
Business Expense - Owner	$ 10,235		
Tractor Payment	$ 5,073		
Fines & Penalties - Charges	$ 205		
Total Other Administrative and General	$ 175,568	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Westview Nursing Care & Rehabilitation	930-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 #

*** 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
Westview Nursing Care & Rehabilitation Center, Inc.	930-C	9/30/2016	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	298,886	298,886		
2. Non-Food Supplies	$	47,612	47,612		
3. Other (*Specify*)_____ Café Expenses	$	32,267	32,267		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	378,765	378,765		

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

H.	Is cost of employee meals included in 2E?	○ 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.	$280
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				Pg 30 - IV1
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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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
Westview Nursing Care & Rehabilitation Center, Inc.	930-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. $	13,774	13,774		
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. $	9,778	9,778		
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)	$	23,552	23,552		

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
Westview Nursing Care & Rehabilitation Cente	930-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.	$	65,213	65,213		
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*)		$	198	198		
Floral Decorations						
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	65,410	65,410		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	266,263	266,263		
RX Health						
b. Medicine Cabinet Drugs		$	7,530	7,530		
c. Medical and Therapeutic Supplies		$	199,987	199,987		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	11,129	11,129		
f. X-rays and Related Radiological Procedures***		$	16,732	16,732		
g. Dental (*Not dentists who should be included under salaries or fees)*		$	22,288	22,288		
h. Laboratory***		$				
i. Recreation		$	11,048	11,048		
j. Other (Specify)****		$	22,591	22,591		
See Attached Schedule						
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	557,567	557,567		

* 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)
IV Medicare Expense	$ 9,419		
IV Managed Medicare Expense	$ 5,441		
IV House Stock Expense	$ 1,376		
IV Contract Expense	$ 4,081		
IV Medicaid Expense	$ 780		
Complex Medical Equipment	$ 1,493		
Total Other Resident Care	$ 22,591	$ -	$ -

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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
Westview Nursing Care & Rehabilitation Center, Inc.	930-C	9/30/2016	21	37

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Westview Nursing Care & Rehabilitation Cent	930-C	9/30/2016	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	121,450	121,450		
b. Heat	$	32,957	32,957		
c. Light & Power	$	111,680	111,680		
d. Water	$	42,840	42,840		
e. Equipment Lease (*Provide detail on page 6*)	$	51,411	51,411		
f. Other (*itemize*)	$	102,447	102,447		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	462,785	462,785		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	23,210	23,210		
b. Building & Building Improvements	$	120,932	120,932		
c. Non-Movable Equipment	$	54,153	54,153		
d. Movable Equipment	$	143,062	143,062		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	341,357	341,357		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	3,390	3,390		
c. Leasehold Improvements	$	131,588	131,588		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	134,978	134,978		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	840,000	840,000		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	85,369	85,369		
c. Personal property taxes	$	15,498	15,498		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,417,201	1,417,201		

* 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)
Fuel - Gas (Cooking)	$ 12,481		
Trash Removal	$ 38,524		
Grounds Maintenance	$ 13,995		
Fire Extinguisher Service	$ 2,017		
Smoke Detector Service	$ 2,572		
Termite and Pest Control	$ 1,245		
Cable TV	$ 11,032		
Minor Furnishings & Equipment	$ 20,580		
Total Other Repairs and Maintenance	$ 102,447	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Westview Nursing Care & Rehabilitation Center, Inc.	930-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	231,955		231,955	121,303	S/L	Various	22,045	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	16,674		16,674		S/L	Various	1,165	
A-4. Subtotal								23,210
B. **Building and Building Improvements**								
1. Acquired prior to this report period	1,589,402		1,589,402	707,322	S/L	Various	112,550	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	114,291		114,291		S/L	Various	8,382	
B-4. Subtotal								120,932
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	506,214		506,214	331,156	S/L	Various	52,092	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	9,305		9,305		S/L	Various	2,060	
C-4. Subtotal								54,153

	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. 2006 Ford 350 Truck	x		5	2007	26,145		26,145	26,145	S/L	5		
b. Ford Van	x				3,067		3,067	3,067	S/L	5		
c. Plow for Truck			12	2015	6,567		6,567		S/L	5	985	
d. Golf Cart			9	2016	4,928		4,928		S/L	5	82	
2. Movable Equipment												
a. Acquired prior to this report period					1,237,835		1,237,835	667,613	S/L	Various	132,503	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					100,316		100,316		S/L	5	9,492	
D-3. Subtotal												143,063
E. ***Total Depreciation***												341,357

Westview Nursing Care & Rehabilitation Center, Inc.
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Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/7/2015	Parking Lot Sealcoating	$ 5,000	10	$ 500	
10/23/2015	Parking Lot Sealcoating	$ 4,995	10	$ 458	
5/4/2016	Landscaping Items - Trees & Plants	$ 3,193	10	$ 133	
5/18/2016	Installation of Trees	$ 1,037	10	$ 35	
6/17/2016	Damage Clean up from Old Trees	$ 1,579	10	$ 39	
9/30/2016	Lot Application	$ 870	10	$ -	
Total additions for Land Improvements		$ 16,674		$ 1,165	*
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:					
10/28/2015	Pediatric Center Improvements	$ 3,750	10	$ 344	
11/7/2015	Roof Repairs	$ 5,700	10	$ 523	
11/1/2015	Nursing Station Carpeting	$ 16,766	10	$ 1,537	
11/2/2015	Dietary Sprinkler System Additions	$ 5,450	10	$ 500	
12/1/2015	PT Wing Carpeting	$ 8,322	10	$ 693	
12/22/2015	New Windows	$ 1,813	10	$ 136	
12/22/2015	New Windows/Glass Table Tops	$ 2,027	10	$ 152	
12/28/2015	Rooftop Heating Tape and Installation	$ 8,600	10	$ 645	
1/1/2016	Pediatric Center Improvements	$ 2,003	10	$ 150	
2/1/2016	Full Upgrade of Power Panels	$ 41,742	10	$ 2,783	
2/23/2016	Fire Rating Downstairs Mechanical Rooms	$ 1,038	10	$ 61	
2/23/2016	Pediatric Center Improvements	$ 2,931	10	$ 171	
3/3/2016	Electrical Closet Annex	$ 4,150	10	$ 242	
4/1/2016	Generator Panel / Main Street	$ 5,477	10	$ 274	
4/28/2016	50 AMP Circuit for Steamer in Kitchen	$ 2,606	10	$ 109	
5/27/2016	New Windows	$ 1,916	10	$ 64	
Total additions for Building Improvements		$ 114,291		$ 8,382	*
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:				
10/9/2015	New Pool Heater	$ 2,680	10	$ 536
12/9/2015	New Pump	$ 1,829	10	$ 1,524
9/30/2016	Dishwasher / Motor Drive Belt	4795.75	10	0

Total additions for Non-Movable Equipment		$ 9,305		$ 2,060	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

Attachment Pages 23 24

***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:					
10/8/2015	Pool Heater	$ 1,108	5	$ 222	
11/1/2015	Extractor	$ 1,521	5	$ 279	
1/21/2016	Love Seat and Chairs	3219.21	5	429.23	
1/28/2016	Floor Machine	1017.77	5	135.7	
2/1/2016	Cubicle Curtains	2520.77	5	336.06	
2/26/2016	Rec Room Fish Tank	1874.63	5	218.71	
2/26/2016	Security Cameras	14091.38	5	1643.99	
2/17/2016	Cambridge Fish Tank	5623.91	5	656.12	
3/4/2016	Steamer / Game Ready System	8919.53	5	1040.61	
3/1/2016	Chairs	1699.69	5	198.3	
4/4/2016	Toaster	1789.22	5	178.92	
5/5/2016	Training Supply Models	2490.11	5	207.51	
5/4/2016	Easystand Evolve E3 Machine	4601.7	5	383.48	
5/16/2016	Televisions	5710.18	5	380.68	
6/7/2016	Cybex Machine	5259.01	5	350.6	
7/7/2016	Ice Machine	2111	5	105.55	
7/26/2016	Vital Signs Monitor	2927.95	5	97.6	
7/5/2016	Beds	3089.45	5	154.47	
7/11/2016	Table/Benches	3092.64	5	154.63	
7/27/2016	Dishwasher/Softener System	2141.88	5	71.4	
9/23/2016	Digital Chair Scale	1048.6	5	0	
9/30/2016	Virtual Reality Program	3300	5	0	
10/31/2015	Computer Systems	3854.25	5	706.61	
1/31/2016	Lenevo Think Center	1570.9	5	209.45	
2/29/2016	HP Smart Computer	2239.32	5	261.25	
3/4/2016	Apple Mac Pro	4721.49	5	550.84	
4/30/2016	Apple Ipad Air	1822.9	5	151.91	
5/2/2016	Mediware Scheduling Software	2472	5	206	
6/30/2016	KnowBrainer Therapy Speech Recog Software	2041.96	5	102.1	
7/29/2016	Color Laser WorkCenter - Therapy	1164.53	5	38.82	
8/31/2016	Xerox Laser WorkCenter - Therapy	1270.88	5	21.18	
Total additions for Movable Equipment		$ 100,316		$ 9,492	*
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:					
Total additions for Leasehold Improvement		$ -		$ -	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Westview Nursing Care & Rehabilitation Center, Inc.	930-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. Construction Loan Closing Costs	11	2005	18 Years	50,970	29,608			2,998	
2. FME Loan Closing Costs	11	2005	11 Years	8,082	7,693			392	
3.									
B-4. Subtotal									3,390
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period				5,131,972	1,104,119			131,588	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									131,588
D. ***Total Amortization***									134,978

* 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
Westview Nursing Care & Rehabilitati	930-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	08/07/74
2. Date Structure Completed	01/01/54
3. If **NOT** Original Owner, Date of Purchase	08/07/74
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	103
6. Square Footage	62,068
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
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.

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

Name of Facility	License No.	Report for Year Ended	Page of
Westview Nursing Care & Rehabilitat	930-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
Westview Nursing Care & Rehabil	930-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*) FME Interest		$	14,485	14,485		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)		$	14,485	14,485		
14. Insurance						
a. Insurance on Property (buildings only)		$	66,211	66,211		
b. Insurance on Automobiles		$	1,482	1,482		
c. Insurance other than Property (as specified above)						
1. Umbrella (*Blanket Coverage*)		$				
2. Fire and Extended Coverage		$				
3. Other (*Specify*) Directors & Officers Insurance		$	11,432	11,432		
14d. ***Total Insurance Expenditures (14a + b + c)***		$	79,124	79,124		
15. ***Total All Expenditures (A-13 thru C-14)***		$	14,244,283	14,244,283		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Westview Nursing Care & Rehabilitation Center, Inc.	930-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.	16		Outpatient Service Costs	$	619,573	619,573		
2.			Salaries not related to Resident Care	$				
3.			Occupational Therapy	$				
4.			Other - See attached Schedule	$	68,597	68,597		
Page 13 - Professional Fees								
5.			Resident Care Physicians **	$				
6.			Occupational Therapy	$				
7.			Other - See attached Schedule	$				
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.	15	1c	Bad Debts	$	6,782	6,782		
10.			Accounting & Legal	$				
11.			Telephone	$				
12.			Cellular Telephone	$				
13.			Life insurance premiums on the life of Owners, Partners, Operators	$				
14.			Gifts, flowers and coffee shops	$				
15.	15	1a9	Education expenditures to colleges or universities for tuition and related costs for owners and employees	$	2,009	2,009		
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.	16	m13	Automobile Expense (e.g. personal use)	$	4,182	4,182		
18.	16	m13	Unallowable Advertising *	$	61,004	61,004		
19.	15	1k1	Income Tax / Corporate Business Tax	$	250	250		
20.			Fund Raising / Contributions	$	25,125	25,125		
21.			Unallowable Management Fees	$				
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$	314,906	314,906		
Page 18 - Dietary Expenditures								
24.			Meals to employees, guests and others who are not residents	$				
Page 19 - Laundry Expenditures								
25.			Laundry services to employees, guests and others who are not residents	$				
Page 20 - Housekeeping Expenditures								
26.			Housekeeping services to employees, guests and others who are not residents	$				
			Subtotal (Items 1 - 26)	$	1,102,428	1,102,428		

* 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)
16	A5b	Café Coordinator - Wages	$ 26,586		
16	A12n	Marketing - Wages	$ 42,012		
Total Other Salaries Adjustment			$ 68,597	$ -	$ -

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)
10	m13	Consulting Fees - Administrator Fee for Consulting Services	$ 103,042		
10	a1	Owner's Wage Disallowance	$ 111,058		
16	m13	Business Expense - Owner	$ 10,235		
18	2a3	Café Expenses	$ 32,267		
15	1b	Deferred Pension	$ 10,008		
		A&G Overhead for Outpatient Therapy (See schedule)	$ 48,297		
Total Other A&G Adjustments			$ 314,906	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Westview Nursing Care & Rehabilitation Center, Inc.	930-C	9/30/2016	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	1,102,428	1,102,428		
Page 20 - Resident Care Supplies***							
27.	20	5a2-5	Prescription Drugs $	273,793	273,793		
28.			Ambulance/Limousine $				
29.	20	5f	X-rays, etc $	16,732	16,732		
30.	20	5f-5h	Laboratory $	22,288	22,288		
31.	20	5c	Medical Supplies $	199,987	199,987		
32.	20	5e2	Oxygen (non emergency) $	11,129	11,129		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	39,702	39,702		
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.		See S	Property Insurance $	4,578	4,578		
Other - Miscellaneous							
42.			Research or Experimental Activities $				
43.	30	IV3	Radio and Television Revenue $	6,541	6,541		
44.	30	IV7	Vending Machine Revenue $	762	762		
45.			Purchase Discounts and Allowances $				
46.			Duplications of functions or services $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest $				
48.	30	IV5	Interest Income on Accounts Rec $	374	374		
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule $	35,363	35,363		
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
51.	***Total Amount of Decrease (Items 1 - 50)*** $			1,713,675	1,713,675		

*** 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

Westview Nursing Care & Rehabilitation Center, Inc.
9/30/2016

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	IV Expenses	$ 21,097		
20	5j	Complex Medical Equipment	$ 1,493		
		Supplies Related to Therapies (See schedule)	$ 17,111		
Total Other Ancillary Costs			$ 39,702	$ -	$ -

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)
30	IV1	Guest Meals Revenue	$ 280		
30	IV2	Parties - Facility Charge Revenue	$ 400		
30	IV7	Café Revenue	$ 34,683		
Total Other Adjustments			$ 35,363	$ -	$ -

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
Westview Nursing Care & Rehabilitation	930-C	9/30/2016	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	5,647,604	5,647,604		
b. Medicaid Room and Board Contractual Allowance **	$	(1,590,849)	(1,590,849)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	3,524,189	3,524,189		
b. Medicare Room and Board Contractual Allowance **	$	2,200,527	2,200,527		
4. a. Private-Pay Residents and Other	$	3,429,813	3,429,813		
b. Private-Pay Room and Board Contractual Allowance **	$	58,369	58,369		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	456,732	456,732		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(437,046)	(437,046)		
c. Prescription Drugs - Non-Medicare	$	8,237	8,237		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(8,237)	(8,237)		
2. a. Medical Supplies - Medicare	$	50,301	50,301		
b. Medical Supplies - Medicare Contractual Allowance **	$	(50,301)	(50,301)		
c. Medical Supplies - Non-Medicare	$	44,018	44,018		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(42,978)	(42,978)		
3. a. Physical Therapy - Medicare	$	2,029,036	2,029,036		
b. Physical Therapy - Medicare Contractual Allowance **	$	(1,887,534)	(1,887,534)		
c. Physical Therapy - Non-Medicare	$	78,902	78,902		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(79,554)	(79,554)		
4. a. Speech Therapy - Medicare	$	159,168	159,168		
b. Speech Therapy - Medicare Contractual Allowance **	$	(108,423)	(108,423)		
c. Speech Therapy - Non-Medicare	$	3,247	3,247		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(3,247)	(3,247)		
5. a. Occupational Therapy - Medicare	$	2,072,398	2,072,398		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(1,933,360)	(1,933,360)		
c. Occupational Therapy - Non-Medicare	$	73,644	73,644		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(73,709)	(73,709)		
6. a. Other *(Specify)* - Medicare	$	146,852	146,852		
b. Other *(Specify)* - Non-Medicare	$	1,002,405	1,002,405		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	14,770,204	14,770,204		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	280	280		
2. Rental of rooms to non-residents	$	400	400		
3. Telephone	$	6,541	6,541		
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	374	374		
6. Private Duty Nurses' Fees	$	763	763		
7. Barber, Coffee, Beauty and Gift shops	$	35,445	35,445		
8. Other (*Specify*)	$	1,844	1,844		
V. Total Other Revenue (1 thru 8)	$	45,646	45,646		
VI. Total All Revenue (III +V)	$	14,815,851	14,815,851		

* *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)
	Medicare B Adjustments - Sequestration - Outpatient Medicare B Revenue	$ 146,852		
Total Other Resident Revenue - Medicare		$ 146,852	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Outpatient Revenue - Non-Medicare	$ 1,002,405		
Total Other Resident Revenue		$ 1,002,405	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest Income		$ 374		
Total Interest Income			$ 374	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Income for Medical Record Copies	$ 1,359		
	Legal/Other Fees	$ (485)		
	Misc. Income	$ 958		
	Small Balance Adjustments	$ 11		
Total Other Revenue		$ 1,844	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Westview Nursing Care & Rehabilitatio	930-C	9/30/2016	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 1,003,157
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 929,425
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 12,432
5. Prepaid Expenses				$ 266,371
a. Prepaid Insurance		53,844		
b. Sec. 444 Tax Deposit		42,647		
c. Reinsurance - Refunds		169,880		
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 2,307
Other Income		2,307		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,213,692
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	248,629		$ 104,116
	Accum. Depreciation	144,513	Net	
3. Buildings	*Historical Cost	1,703,693		$ 875,439
	Accum. Depreciation	828,254	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	515,519		$ 130,210
	Accum. Depreciation	385,309	Net	
6. Movable Equipment	*Historical Cost	1,338,150		$ 528,542
	Accum. Depreciation	809,608	Net	
7. Motor Vehicles	*Historical Cost	40,707		$ 10,428
	Accum. Depreciation	30,279	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 1,648,733

* 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
Westview Nursing Care & Rehabilitatic	930-C	9/30/2016	32	37

Account				Amount
			Total Brought Forward:	$ 3,862,425
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost	5,191,024		
	Accum. Depreciation	1,276,395	Net	$ 3,914,629
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)				$ 3,914,629
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*)				$
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 7,777,054

* 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
Westview Nursing Care & Rehabilitation Cent	930-C	9/30/2016	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 203,844
2. Notes Payable (*itemize*)					$ (3,000)
A/P Suspense Account			(3,000)		
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*)					$ 140,881
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$
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*					$ 250
12. Other Current Liabilities (*itemize*)					$ 1,263,984
Accrued Vacation Benefit	217,838	Deferred Revenue	77,896		
Accrued Health Insurance	768,523	Resident Trust/Rec Fund	34,695		
Accrued Interest	671	Provider Tax Liability	149,762		
Garnishments/Employee Tuition	3,736	Current Portion - LTD	10,862		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 1,605,959

* 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
Westview Nursing Care & Rehabilitation C	930-C	9/30/2016	34	37

Account	Amount
Total Brought Forward:	1,605,959
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$ 375,175

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$ (3,932,008)

Name and Address of Lender	Amount	Loan Date
Czermak/Katz	77,218	
Due to/from Landlord	(4,009,226)	

4. Other Long-Term Liabilities (*itemize*)		$ (239,712)
Due to/from Country Living	(237,809)	
AMFS	(1,904)	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ (3,796,545)
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ (2,190,586)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Westview Nursing Care & Rehabilitati	930-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	$ 5,182,942
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$ 5,182,942
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$ 4,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 4,209,131
	6. Gain or Loss for Period 10/1/2015 thru 9/30/2016	$ 571,567
	7. Total Net Worth	$ 4,784,698
C.	***Total Reserves and Net Worth***	$ 9,967,640
D.	***Total Liabilities, Reserves, and Net Worth***	$ 7,777,054

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Westview Nursing Care & Rehabilitation	930-C	9/30/2016	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2015			$ 4,515,027
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 14,815,851
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 14,244,283
D.	Net Income or Deficit			$ 571,567
E.	Balance			$ 5,086,594
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period*** 09/30/16			$ 5,086,594

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-37 Rev. 9/2002

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Westview Nursing Care & Rehabilitation	930-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	
Donna LaHaie	
Addres Address	Phone Number
150 Ware Road Dayville, CT 06241	860-774-8574