

State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2019

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 <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019

License Numbers:	CCNH 930-C	RHNS	(Specify)	Medicare Provider 075078
------------------	---------------	------	-----------	-----------------------------

Medicaid Provider Numbers:	CCNH 9308	RHNS	ICF-IID
----------------------------	--------------	------	---------

For Department Use Only

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

General Information

Name of Facility (as licensed) Westview Nursing Care & Rehabilitation Center, Inc.	License No. 930-C	Report for Year Ended 9/30/2019	Page 1	of 37
---	----------------------	------------------------------------	-----------	----------

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Westview Nursing Care & Rehabilitation Center, Inc. [facility name], for the cost report period beginning October 1, 2018 and ending September 30, 2019, 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)

Table of Contents

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

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Westview Nursing Care & Rehabilitation Center, Inc.	Period Covered:	From 10/1/2018	To 9/30/2019	
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.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-774-8574		Report for Year Ended 9/30/2019	Page 2	of 37
Name of Facility (as shown on license) Westview Nursing Care & Rehabilitation Center, Inc.		Address (No. & Street, City, State, Zip) 150 Ware Road Dayville, CT 06241		
License Numbers:	CCNH 930-C	RHNS	(Specify)	Medicare Provider No. 075078
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator David T. Panteleakos		Nursing Home Administrator's License No.:	1129	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

General Information and Questionnaire Corporate Owners

Name of Facility Westview Nursing Care & Rehabilitation Cen	License No. 930-C	Report for Year Ended 9/30/2019	Page 3A	of 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	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Chaim H. Czermak	1018 New McNeil Avenue, Lawrence, NY 11559	resident/Treasur	200	
Marvin Czermak	1049 East 23rd Street, Brooklyn, NY 11210	ice-Pres./Secreta	100	
Maurice Katz	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 11559	resident/Treasur	50	
Marvin Czermak	1049 East 23rd Street, Brooklyn, NY 11210	ice-Pres./Secreta	25	
Maurice Katz	35 Broadway, Lawrence, NY 11559	Director	12.5	
Isabelle Katz	1 Regent Drive, Lawrence, NY 11559	Director	12.5	

**General Information and Questionnaire
Related Parties***

Name of Facility Westview Nursing Care & Rehabilitation Center, Inc.	License No. 930-C	Report for Year Ended 9/30/2019	Page 4	of 37
---	----------------------	------------------------------------	-----------	----------

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

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Westview Land Company	Same as facility	<input type="radio"/>	<input checked="" type="radio"/>		Lessor	Pg. 22/Line 9	840,000	
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

* 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 Westview Nursing Care & Rehabilitation Center	License No. 930-C	Report for Year Ended 9/30/2019	Page 5	of 37
---	----------------------	------------------------------------	-----------	----------

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

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

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

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

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

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.

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
Westview Nursing Care & Rehabilitation Center, Inc.		930-C		9/30/2019			6	37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease		Amount Claimed
	Yes	No						
US Bank	<input type="radio"/>	<input checked="" type="radio"/>	Printers/Copiers	04/11/18	60 Months			
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
							Total ***	

Is a Mileage Log Book Maintained for All Leased Vehicles ? Yes No **Total *****

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

General Information and Questionnaire
Accounting Basis

Name of Facility Westview Nursing Care & Rehabili	License No. 930-C	Report for Year Ended 9/30/2019	Page 7	of 37
--	----------------------	------------------------------------	-----------	----------

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

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

Independent Accounting Firm

Name of Accounting Firm 1 Marcum LLP 2 3 4	Address (No. & Street, City, State, Zip Code) 555 Long Wharf Dr. New Haven, CT 06511
--	---

Services Provided by This Firm (*describe fully*)

1 Annual financial audit and review; financial statements; annual corporate taxes, financial advisement	\$ 13,442
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 13,442

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

Legal Services Information

Name of Legal Firm or Independent Attorney 1 Wigin & Dana 2 Northeast Credit Services 3 Bachand, Longo & Higgins 4 5	Telephone Number 203-498-4400 860-872-0686 860-928-6549
---	--

Address (*No. & Street, City, State, Zip Code*)
 1 One Century Tower, New Haven, CT
 2 117 Hartford Pike, Tolland, CT
 3 168 Main Street, Putnam, CT 06260
 4
 5

Services Provided by This Firm (*describe fully*)

1	\$ 3,075
2 AR Collenctions	\$ 1,010
3 Legal Fees associated with property acquisitions and refi.	\$ 3,576
4	\$
5	\$
	Charge for Services Provided
	\$ 7,661

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

Schedule of Resident Statistics

Name of Facility Westview Nursing Care & Rehabilitation Center, Inc.			License No. 930-C		Report for Year Ended 9/30/2019				Page 8		of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	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	100	100			100	100			101	101		
B. As of midnight of THIS report period	103	103			101	101			103	103		
3. Total Number of Days Care Provided During Period												
A. Medicare	10,258	10,258			8,079	8,079			2,179	2,179		
B. Medicaid (Conn.)	14,123	14,123			10,496	10,496			3,627	3,627		
C. Medicaid (other states)												
D. Private Pay	12,233	12,233			8,750	8,750			3,483	3,483		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	36,614	36,614			27,325	27,325			9,289	9,289		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	66	66			50	50			16	16		
B. Other Bed Reserve Days	54	54			53	53			1	1		
5. Total Resident Days (3G + 4A + 4B)	36,734	36,734			27,428	27,428			9,306	9,306		

Schedule of Resident Statistics (Cont'd)

Name of Facility Westview Nursing Care & Rehabilitation Cen			License No. 930-C			Report for Year Ended 9/30/2019			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days									CCNH	RHNS	(Specify)		
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid			Self-Pay			Other State Assisted				
	CCNH	RHNS	CCNH	RHNS	(Specify)	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR			
No. of Residents	22		44			36		1					
Per Diem Rate													
a. One bed rm.													
b. Two bed rms.	631.00		250.14			338.00		540.00					
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									16,859	16,859			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									72,670	72,670			
D. Total Physical Therapy Treatments									89,529	89,529			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									416	416			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									1,563	1,563			
D. Total Speech Therapy Treatments									1,979	1,979			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									5,051	5,051			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									33,358	33,358			
D. Total Occupational Therapy Treatments									38,409	38,409			

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility Westview Nursing Care & Rehabilitation Center, Inc.	License No. 930-C	Report for Year Ended 9/30/2019	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)	132,066	2,080				
2. Administrator(s) (Complete also Sec. III of Schedule A1)	92,181	2,207				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	696,797	22,414				
5. Dietary Service						
a. Head Dietitian	38,170	892				
b. Food Service Supervisor	69,680	2,501				
c. Dietary Workers	414,729	24,825				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	206,653	15,332				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	114,082	13,763				
b. Other Maintenance Workers	244,469	2,200				
8. Laundry Service						
a. Supervisor	48,402	2,219				
b. Other Laundry Workers	155,217	7,404				
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	126,721	2,162				
b. RN						
1. Direct Care	1,358,269	37,411				
2. Administrative**	139,283	4,797				
c. LPN						
1. Direct Care	712,884	25,139				
2. Administrative**						
d. Aides and Attendants	2,008,692	115,572				
e. Physical Therapists	1,301,233	40,458				
f. Speech Therapists	143,427	2,523				
g. Occupational Therapists	573,534	17,017				
h. Recreation Workers	127,049	5,742				
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	143,890	4,375				
n. Marketing	94,508	3,611				
o. Other (Specify)						
See Attached Schedule	616,826	21,290				
A-13. Total Salary Expenditures	9,558,762	375,934				

* 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)

Position	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Unit Secretary	\$ 91,146	3,990				
PT Salaries - Contracted	\$ 112,070	2,222				
OT Salaries - Contracted	\$ 140,958	3,495				
ST Salaries - Contracted	\$ 62,471	1,502				
Administrative Therapy Assistants	\$ 71,442	3,794				
Administrative Sports Therapy Assistants	\$ 81,344	4,169				
Admissions Coordinator	\$ 57,395	2,118				
Total	\$ 616,826	21,290	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

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

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

Name of Facility				License No.		Report for Year Ended			Page	of
Westview Nursing Care & Rehabilitation Center, Inc.				930-C		9/30/2019			11	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Herbert Czermak	132,066				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.

**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	
Westview Nursing Care & Rehabilitation Center, Inc.				930-C	9/30/2019			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
David T. Panteleakos	92,181				Administrator	2,207	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.

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	9/30/2019	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	3,000	197				
4. Podiatrist	2,007	28				
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	35,502	277				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	175	1				
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
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	40,684	502				

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

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

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Westview Nursing Care & Rehabilitation Center,	930-C	9/30/2019	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 145,024	A 145,024		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 94,736	94,736		
4. Social Security (F.I.C.A.)	\$ 714,113	714,113		
5. Health Insurance	\$ 712,016	712,016		
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 16,467	16,467		
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 133,631	133,631		
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$ 11,213	11,213		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$ 20,933	20,933		
c. Bad Debts*	\$ 17,717	17,717		
d. Accounting and Auditing	\$ 13,442	13,442		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 7,661	7,661		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 42,612	42,612		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 23,544	23,544		
2. Cellular Phones	\$ 4,438	4,438		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$			
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$ 73,686	73,686		
2. Other (<i>Specify</i>) See Attached Schedule	\$ 250	250		
3. Resident Day User Fee	\$ 556,526	556,526		
Subtotal	\$ 2,588,009	2,588,009		

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

(Carry Subtotals forward to next page)

Sum of A (Total Fringes) = 1,820,955

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	9/30/2019		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:		2,588,009	2,588,009		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	4,884	4,884		
3. Gifts to Staff and Residents	\$	18,935	18,935		
4. Employee Travel	\$	2,070	2,070		
5. Education Expenses Related to Seminars and Conventions	\$	25,520	25,520		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$	8,910	8,910		
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	33,920	33,920		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	113,326	113,326		
4. Fund-Raising***	\$				
5. Medical Records	\$	11,987	11,987		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$	5,479	5,479		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	5,457	5,457		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$	3,941	3,941		
10. Contributions*** See Attached Schedule	\$	14,540	14,540		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$				
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$	231,953	231,953		
C-14 Total Administrative & General Expenditures	\$	3,068,930	3,068,930		

* 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)
Promotional Advertising	\$ 114		
Community Education Advertising	\$ 113,212		
Total Other Advertising	\$ 113,326	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Membership Fees	\$ 2,876		
License Fees	\$ 2,581		
Total Dues	\$ 5,457	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Donations	\$ 14,540		
Total Contributions	\$ 14,540	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Computer Operations Support	\$ 50,404		
Unallowable Auto Expense	\$ 15,474		
Business Expense - Owner	\$ 11,341		
Tractor	\$ 2,536		
Office Space Rental Expense	\$ 23,500		
Bank Charges & Credit Card Processing Fees	\$ 25,510		
Consulting Fees - Administrator Fee for Consulting (Disallowed)	\$ 103,188		
Total Other Administrative and General	\$ 231,953	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Westview Nursing Care & Rehabilitation	License No. 930-C	Report for Year Ended 9/30/2019	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)

Name of Facility	License No.	Report for Year Ended	Page	of
Westview Nursing Care & Rehabilitation Center, Inc.	930-C	9/30/2019	18	37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 318,907	318,907		
2. Non-Food Supplies	\$ 32,919	32,919		
3. Other (Specify) _____	\$ _____			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ _____			
c. Other (Specify) _____	\$ _____			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 351,827	351,827		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*				
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				
H. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D? <input checked="" type="radio"/> Yes <input type="radio"/> No If yes, specify cost.				
K. Is any revenue collected from these people? <input checked="" type="radio"/> Yes <input type="radio"/> No If yes, specify amt.				
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				Pg 30 - IV1
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.				
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
O. 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.

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

Name of Facility Westview Nursing Care & Rehabilitation Center, Inc.		License No. 930-C	Report for Year Ended 9/30/2019		Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)	
3. Laundry						
a. In-House Processing*		Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$	12,521	12,521		
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. \$	11,285	11,285		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$				
c. Other (Specify)		\$				
3D. Total Laundry Expenditures (3a + b + c)		\$	23,805	23,805		
3E. Laundry Questionnaire						
F.	Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
G.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
H.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
I.	Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
K.	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 3D.

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Westview Nursing Care & Rehabilitation Center		930-C	9/30/2019		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
	a. In-House Care					
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	74,009	74,009		
	b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt. \$				
	C. Other (<i>Specify</i>)		\$			
4D.	Total Housekeeping Expenditures (4a + b + c)		\$ 74,009	74,009		
5.	Resident Care (Supplies)**					
	a. Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from	\$	402,769	402,769		
	b. Medicine Cabinet Drugs	\$	9,349	9,349		
	c. Medical and Therapeutic Supplies	\$	194,822	194,822		
	d. Ambulance/Limousine***	\$				
	e. Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	14,489	14,489		
	f. X-rays and Related Radiological Procedures***	\$	23,045	23,045		
	g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
	h. Laboratory***	\$	33,745	33,745		
	i. Recreation	\$	13,468	13,468		
	j. Direct Management Services*	\$				
	k. Indirect Management Services*	\$				
	l. Other (Specify)**** See Attached Schedule	\$	41,120	41,120		
5M.	Total Resident Care Expenditures (5a - 5j)		\$ 732,808	732,808		

* 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	\$ 28,721		
IV Medicare Advantage	\$ 927		
IV House Stock	\$ 3,986		
IV Medicaid	\$ 1,159		
Complex Medical Equipment - Medicare	\$ 2,670		
Nurse Practitioner Supplies	\$ 3,658		
Total Other Resident Care	\$ 41,120	\$ -	\$ -

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

Name of Facility Westview Nursing Care & Rehabilitation Center, Inc.			License No. 930-C	Report for Year Ended 9/30/2019	Page of 21 37						
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***					
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line	
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								
		<input type="radio"/>	<input checked="" type="radio"/>								

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
Westview Nursing Care & Rehabilitation Cen	930-C	9/30/2019			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 133,933	133,933				
b. Heat	\$ 56,505	56,505				
c. Light & Power	\$ 120,118	120,118				
d. Water	\$ 50,243	50,243				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 79,417	79,417				
f. Other (<i>itemize</i>)	\$ 91,144	91,144				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 531,360	531,360				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$ 50,146	50,146				
b. Building & Building Improvements	\$ 263,780	263,780				
c. Non-Movable Equipment	\$ 35,070	35,070				
d. Movable Equipment	\$ 158,818	158,818				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 507,814	507,814				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$ 2,998	2,998				
c. Leasehold Improvements	\$ 131,588	131,588				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 134,586	134,586				
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	\$ 122,458	122,458				
c. Personal property taxes	\$ 16,785	16,785				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,621,644	1,621,644				

* 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)	\$ 14,561		
Trash Removal	\$ 25,436		
Grounds Maintenance	\$ 23,174		
Security Expense	\$ 1,230		
Fire Extinguisher Service	\$ 2,613		
Termite & Pest Control	\$ 1,417		
Plant Operations Purchased Services	\$ 12,049		
Minor Furnishings & Equipment	\$ 10,689		
Adjustment to Depreciation	\$ (25)		
Total Other Repairs and Maintenance	\$ 91,144	\$ -	\$ -

Depreciation Schedule

Name of Facility Westview Nursing Care & Rehabilitation Center, Inc.			License No. 930-C		Report for Year Ended 9/30/2019			Page 23	of 37				
Property Item			Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals			
A. Land Improvements													
1. Acquired prior to this report period			640,600		640,600	217,101	SL	Various	48,376				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			64,947		64,947		SL	Various	1,770				
A-4. Subtotal										50,146			
B. Building and Building Improvements													
1. Acquired prior to this report period			2,325,091		2,325,091	1,111,607	SL	Various	158,839				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			1,166,508		1,166,508		SL	Various	104,941				
B-4. Subtotal										263,780			
C. Non-Movable Equipment													
1. Acquired prior to this report period			632,312		632,312	459,063	SL	Various	32,685				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			59,753		59,753		SL	Various	2,385				
C-4. Subtotal										35,070			
		Is a mileage logbook maintained?		Date of Acquisition									
		Yes	No	Month	Year	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
D. Movable Equipment													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a. 2006 Ford 350		x		5	2007	26,145		26,145	26,145	SL	5		
b. Ford Van		x				3,067		3,067	3,067	SL	5		
c. Plow Truck				12	2015	6,567		6,567	3,612	SL	5	1,313	
d. Golf Cart				9	2016	4,928		4,928	2,053	SL	5	986	
2. Movable Equipment													
a. Acquired prior to this report period						1,560,790		1,560,790	1,108,360	SL	Various	147,831	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)						108,657		108,657				8,687	
D-3. Subtotal													158,818
E. Total Depreciation													507,813

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
4/8/2019	LAWN SCULPTURE-FAMILY	\$ 11,500	10	\$ 575
6/11/2019	DRIVEWAY-124 WARE ROAD	\$ 10,210	10	\$ 340
6/11/2019	SCULPTURE INSTALL W/GARDEN AREA	\$ 9,891	10	\$ 330
6/11/2019	SIDEWALK/CURB/LOAM/PLANTING BOXES	\$ 5,530	10	\$ 184
6/8/2019	GARDEN BARN-LANDSCAPING MATERIAL	\$ 3,207	10	\$ 107
6/21/2019	FLOWERS/SCULPTURE AREA	\$ 1,060	10	\$ 26
7/1/2019	LANDSCAPING & PLANTINGS	\$ 1,272	10	\$ 32
8/27/2019	TREE REMOVAL	\$ 19,834	10	\$ 165
9/10/2019	TREE REMOVAL	\$ 500	10	\$ 4
9/10/2019	TRAFFIC CONTROL FOR WATER LINE CONNECT.	\$ 672	10	\$ 6
9/19/2019	STUMP GRINDING	\$ 1,272	10	\$ -
Total additions for Land Improvement		\$ 64,947		\$ 1,770 *
Deletions:				
Total deletions for Land Improvement		\$ -		\$ - **

*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:				
10/25/2018	WATER HOOK UP	\$ 398,100	10	\$ 36,493
11/9/2018	WATER HOOK UP-FINAL	\$ 663,500	10	\$ 60,821
10/18/2018	NEW FLOORING-19 W.WING PATIENT RMS	\$ 40,241	10	\$ 3,689
11/26/2018	STONE WALL REPAIR	\$ 2,200	10	\$ 183
1/24/2019	FLOORING-2 W.WING PATIENT RMS	\$ 13,360	10	\$ 891
2/24/2019	FLOORING-1 W.WING 3 REHAB WING	\$ 49,107	10	\$ 2,865
Total additions for Building Improvement		\$ 1,166,508		\$ 104,941 *
Deletions:				
Total deletions for Building Improvement		\$ -		\$ - **

*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:				
1/1/2019	INSTALL ROOFTOP LIGHTS-PARKING	\$ 5,323	10	\$ 399
1/31/2019	CHLORINE INJECTION SYSTEM	\$ 7,325	10	\$ 488
5/11/2019	REPAIR TO KITCHEN A/C, EVAPS	\$ 13,480	10	\$ 562
5/2/2019	WIRING/PIPE ON ROOF TO A/C UNITS-ANNEX	\$ 8,762	10	\$ 365
5/30/2019	INSTALL/START UP-CHEMICAL INJECTION SYSTEM	\$ 9,957	10	\$ 332
5/31/2019	REPLACE GARBAGE DISPOSAL	\$ 1,202	10	\$ 40
6/30/2019	DAIKEN INVERTER COMPRESSOR	\$ 4,946	10	\$ 124
8/2/2019	UPGRADES TO BOILER	3145.06	10	52.42
8/31/2019	FAUCETS	1649.28	10	13.74
9/20/2019	WATER MAIN VALVES/ICE MAKER LINE	2917.36	10	0
9/8/2019	POOL AND SPA HEATER	1047.55	10	8.73

Total additions for Non-Movable Equipment		\$ 59,753		\$ 2,385	Attachment Pages 23 24
Deletions:					
Total deletions for Non-Movable Equipment		\$ -		\$ -	**

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Annual Report of Long-Term Care Facility

CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility			License No.		Report for Year Ended			Page	of
Westview Nursing Care & Rehabilitation Center, Inc.			930-C		9/30/2019			24	37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1. Construction Closing Costs	11	2005	18 Years	50,970	38,602			2,998	
2. FME Loan Closing Costs	11	2005	11 Years	8,082	8,082				
3.									
B-4. Subtotal									2,998
C. Leasehold Improvements and Other									
1. Acquired prior to this report period				5,131,972	1,498,883			131,588	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									131,588
D. Total Amortization									134,586

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility Westview Nursing Care & Rehabilitati	License No. 930-C	Report for Year Ended 9/30/2019	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*			<input type="radio"/> Yes	<input checked="" type="radio"/> No	
			If "Yes," complete Part B. If "No," complete Part C.		
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description		Total			
1. Date Land Purchased		08/07/74			
2. Date Structure Completed		01/01/54			
3. If NOT Original Owner, Date of Purchase					
4. Date of Initial Licensure		08/07/74			
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.

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

Name of Facility		License No.	Report for Year Ended			Page	of
Westview Nursing Care & Rehabilitation		930-C	9/30/2019			26	37
Item		Total	CCNH	RHNS	(Specify)		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
2. Second Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
3. Third Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
4. Fourth Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount		\$					
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expense							
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$					

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Westview Nursing Care & Rehabil		930-C		9/30/2019		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/LOC				\$ 20,502	20,502		
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$ 20,502	20,502		
14. Insurance							
a. Insurance on Property (buildings only)				\$ 70,151	70,151		
b. Insurance on Automobiles				\$ 3,730	3,730		
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$			
2. Fire and Extended Coverage				\$			
3. Other (Specify) Directors & Officers Insurance				\$ 13,728	13,728		
14d. Total Insurance Expenditures (14a + b + c)				\$ 87,609	87,609		
15. Total All Expenditures (A-13 thru C-14)				\$ 16,111,939	16,111,939		

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	9/30/2019	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.	10		Outpatient Service Costs	\$ 1,024,818	1,024,818		
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 520,355	520,355		
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	\$ 17,717	17,717		
10.			Accounting	\$			
10a.			Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.	16	m13	Automobile Expense (e.g. personal use)	\$ 15,474	15,474		
18.	16	m3	Unallowable Advertising *	\$ 113,212	113,212		
19.			Income Tax / Corporate Business Tax	\$			
20.	16	m10	Fund Raising / Contributions	\$ 14,540	14,540		
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 190,168	190,168		
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)				\$ 1,896,284	1,896,284		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	A12e	PT - Contracted Services	\$ 112,070		
10	A12f	ST - Contracted Services	\$ 62,471		
10	A12g	OT - Contracted Services	\$ 140,958		
10	A12n	Marketing Wages	\$ 94,508		
10	1a	Wages - Owner	110,347		
Total Other Salaries Adjustment			\$ 520,355	\$ -	\$ -

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)
15	1b	Deferred Pension	\$ 20,933		
16	m13	Business Expense - Owner	\$ 11,341		
16	m13	Consulting Fees - Administrator Fee for Consulting Services	\$ 103,188		
		A&G Overhead for Outpatient Services (See Schedule)	54,707		
Total Other A&G Adjustments			\$ 190,168	\$ -	\$ -

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	9/30/2019	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,896,284	1,896,284		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 402,769	402,769		
28.			Ambulance/Limousine	\$			
29.	20	5f	X-rays, etc	\$ 23,045	23,045		
30.	20	5a2	Laboratory	\$ 33,745	33,745		
31.	20	5c	Medical Supplies	\$ 177,378	177,378		
32.	20	5 e2	Oxygen (non emergency)	\$ 14,489	14,489		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 73,821	73,821		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 16,681	16,681		
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	\$ 7,621	7,621		
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$ 4,851	4,851		
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 2,650,684	2,650,684		

*** 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.

Total Other Adjustments			\$	-	\$	-	\$	-

Schedule of Other - Miscellaneous Administrative Adjustments

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

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

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Westview Nursing Care & Rehabilitation	930-C	9/30/2019		30	37
Item	Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 4,772,703	4,772,703			
b. Medicaid Room and Board Contractual Allowance **	\$ (1,291,053)	(1,291,053)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 3,557,318	3,557,318			
b. Medicare Room and Board Contractual Allowance **	\$ 2,733,060	2,733,060			
4. a. Private-Pay Residents and Other	\$ 4,271,139	4,271,139			
b. Private-Pay Room and Board Contractual Allowance **	\$ 99,884	99,884			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 622,799	622,799			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (619,774)	(619,774)			
c. Prescription Drugs - Non-Medicare	\$ 4,430	4,430			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (5,173)	(5,173)			
2. a. Medical Supplies - Medicare	\$ 61,844	61,844			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (37,375)	(37,375)			
c. Medical Supplies - Non-Medicare	\$ 41,689	41,689			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (19,025)	(19,025)			
3. a. Physical Therapy - Medicare	\$ 3,220,638	3,220,638			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (2,666,778)	(2,666,778)			
c. Physical Therapy - Non-Medicare	\$ 3,375,394	3,375,394			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (2,132,204)	(2,132,204)			
4. a. Speech Therapy - Medicare	\$ 260,048	260,048			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (234,943)	(234,943)			
c. Speech Therapy - Non-Medicare	\$ 2,730	2,730			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (1,950)	(1,950)			
5. a. Occupational Therapy - Medicare	\$ 2,127,779	2,127,779			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (2,029,238)	(2,029,238)			
c. Occupational Therapy - Non-Medicare	\$ 63,986	63,986			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (62,686)	(62,686)			
6. a. Other (<i>Specify</i>) - Medicare	\$ 32,930	32,930			
b. Other (<i>Specify</i>) - Non-Medicare	\$ (42,079)	(42,079)			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 16,106,093	16,106,093			
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$ 1,400	1,400			
2. Rental of rooms to non-residents	\$				
3. Telephone	\$ 6,181	6,181			
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$ 397	397			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ 436,668	436,668			
V. Total Other Revenue (1 thru 8)	\$ 444,646	444,646			
VI. Total All Revenue (III +V)	\$ 16,550,738	16,550,738			

* 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)
	Lab, X-ray - Medicare/Mdg Medicare	\$ 70,206		
	Lab, X-ray - Medicare/MA Contractual Allowance	\$ (37,276)		
	Total Other Resident Revenue - Medicare	\$ 32,930	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Lab, X-Ray - Non-Medicare	\$ 1,255		
	Lab, X-Ray - Non-Medicare CA	\$ (43,334)		
	Total Other Resident Revenue	\$ (42,079)	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest Income		\$ 397		
			\$ -		
			\$ -		
			\$ -		
	Total Interest Income		\$ 397	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Medical Records - Copy Charges	\$ 368		
	Legal/Other Fees	\$ (405)		
	Contracted Therapy Services	\$ 430,002		
	Vending Income	\$ 1,736		
	Misc. Income	\$ 5,277		
	Small Balance Adjustments	\$ (310)		
	Total Other Revenue	\$ 436,668	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Westview Nursing Care & Rehabilitatio	930-C	9/30/2019	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	224,242
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,323,054
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	12,432
5. Prepaid Expenses			\$	158,020
a. Prepaid Insurance	63,777			
b. Sec. 444 Tax Deposit	94,243			
c. _____				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	2,311
Other Income	2,307			
Rounding Adj.	4			
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,720,059
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	705,547	\$	438,300
	Accum. Depreciation	267,247		Net
3. Buildings	*Historical Cost	3,491,599	\$	2,116,212
	Accum. Depreciation	1,375,387		Net
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation			Net
5. Non-Movable Equipment	*Historical Cost	692,065	\$	197,933
	Accum. Depreciation	494,132		Net
6. Movable Equipment	*Historical Cost	1,669,446	\$	404,568
	Accum. Depreciation	1,264,879		Net
7. Motor Vehicles	*Historical Cost	40,707	\$	3,531
	Accum. Depreciation	37,176		Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	3,160,543

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			\$ -

Schedule of Other Current Assets (itemized) Page 31 Line A8

Page Ref	Line Ref	Description	
Total Other Current Assets (Itemize)			\$ -

Schedule of Other Fixed Assets (Itemize) Page 31 Line B9

Page Ref	Line Ref	Description	
Total Other Fixed Assets (Itemize)			\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

Schedule of Other Current Liabilities (Itemize) Page 33 Line A12

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			\$ -

Schedule of Other Long-Term Liabilities (Itemize) Page 34 Line B4

Page Ref	Line Ref	Description	
Total Other Long-Term Liabilities (Itemize)			\$ -

G. Balance Sheet (cont'd)

Name of Facility Westview Nursing Care & Rehabilitatio	License No. 930-C	Report for Year Ended 9/30/2019	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	4,880,601
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements			*Historical Cost _____	
			Accum. Depreciation _____	Net
			\$	
3. Buildings			*Historical Cost <u>5,191,024</u>	
			Accum. Depreciation <u>1,680,157</u>	Net
			\$	3,510,867
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)			\$	3,510,867
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense			*Historical Cost _____	
			Accum. Depreciation _____	Net
			\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

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

See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	8,391,468

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

Annual Report of Long-Term Care Facility

CSP-33 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Westview Nursing Care & Rehabilitation Cen		930-C	9/30/2019	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	289,755
2. Notes Payable (<i>itemize</i>)				\$	

See Schedule					
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	234,296
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	5,261
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	671
11. Accrued Income Taxes*				\$	30,291
12. Other Current Liabilities (<i>itemize</i>)				\$	1,105,680
Garnishments/Employee Tuition Fur		3,587	Deferred Revenue	205,098	
Current Portion - LTD		12,500	Resident Trust/Recreatio	29,758	
Accrued Vacation		232,070	Provider Tax Liability/D	151,617	
Accrued Health Insurance		471,051	See Schedule		
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	1,665,954

* 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 Westview Nursing Care & Rehabilitation Ce		License No. 930-C	Report for Year Ended 9/30/2019	Page 34	of 37
Account				Amount	
Total Brought Forward:				1,665,954	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					
				\$	519,195
Name of Lender		Purpose	Amount	Date Due	
Berkshire Bank		FME	339,195		
Berkshire Bank		LOC	180,000		
2. Mortgages Payable					\$
3. Loans from Owners or Related Parties (<i>itemize</i>)					\$ (4,678,360)
Name and Address of Lender		Amount	Loan Date		
Czermak/Katz		77,218			
Due to/from Landlord		(4,755,578)			
4. Other Long-Term Liabilities (<i>itemize</i>)					\$ (378,722)
AMFS/Villa			(26,324)		
Due to/from Country Living			(296,900)		
Due to/from Daview			(55,498)		
See Schedule					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)					\$ (4,537,887)
C. Total All Liabilities (Lines A-13 + B-5)					\$ (2,871,933)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Westview Nursing Care & Rehabilitation	930-C	9/30/2019	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	5,182,942
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			\$	5,637,660
6. Gain or Loss for Period			\$	438,799
	10/1/2018	thru 9/30/2019		
7. Total Net Worth			\$	6,080,460
C. Total Reserves and Net Worth			\$	11,263,402
D. Total Liabilities, Reserves, and Net Worth			\$	8,391,468

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Westview Nursing Care & Rehabilitation	930-C	9/30/2019	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2018			\$	6,349,517
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	16,550,739
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	16,111,939
D. Net Income or Deficit			\$	438,799
E. Balance			\$	6,788,317
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period			\$	6,788,317
				09/30/19

I. Preparer's/Reviewer's Certification

Name of Facility Westview Nursing Care & Rehabilitation	License No. 930-C	Report for Year Ended 9/30/2019	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Donna LaHaie				
Address Address			Phone Number	
28 Cloran Street Putnam, CT 06260			860-428-4872	
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number	
Donna LaHaie			860-774-8574	
Contact Email Address				
dlvl@snet.net				