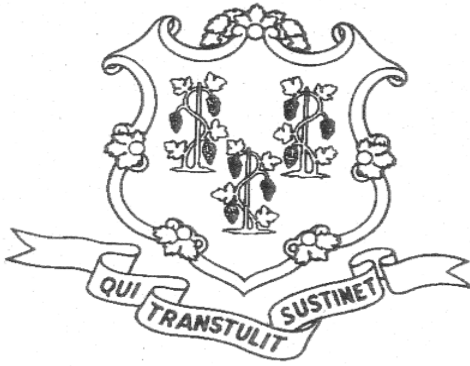


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2015

Name of Facility (as licensed) Westfield Care & Rehab	
Address (No. & Street, City, State, Zip Code) 65 Westfield Rd Meriden CT 06450	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH 980-C	RHNS	(Specify)	Medicare Provider 07-5205
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Medicaid Provider Numbers:	CCNH 208367	RHNS	ICF-IID
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For Department Use Only

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

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General Information

Name of Facility (as licensed) Westfield Care & Rehab	License No. 980-C	Report for Year Ended 9/30/2015	Page 1	of 37
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Administrator's/Owner's Certification

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

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

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

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

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

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Westfield Care & Rehab		Period Covered:	From 10/1/2014	To 9/30/2015
Address of Facility 65 Westfield Rd Meriden CT 06450				
Report Prepared By Apple Health Care, Inc.		Phone Number (860) 678-9755	Date	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-238-1291		Report for Year Ended 9/30/2015		Page 2	of 37
Name of Facility (as shown on license) Westfield Care & Rehab			Address (No. & Street, City, State, Zip) 65 Westfield Rd Meriden CT 06450		
License Numbers:		CCNH 980-C	RHNS	(Specify)	Medicare Provider No. 07-5205
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 Renee Cole			Nursing Home Administrator's License No.:	1859	
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 Westfield Care & Rehab	License No. 980-C	Report for Year Ended 9/30/2015	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation Westfield Care & Rehab	Business Address 65 Westfield Rd Meriden CT 06450	State(s) in Which Incorporated Connecticut		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Brian J. Foley	21 Waterville Road Avon, CT 06001	President	100	
Ryan Vess	21 Waterville Road Avon, CT 06001	Secretary		
Names of Stockholders Owning at Least 10% of Shares				
Brian J. Foley	21 Waterville Road Avon, CT 06001	President	100	

**General Information and Questionnaire
 Related Parties***

Name of Facility Westfield Care & Rehab	License No. 980-C	Report for Year Ended 9/30/2015	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Brian J. Foley	21 Waterville Road Avon, CT	<input type="radio"/>	<input checked="" type="radio"/>		Real Estate Rental	Pg. 22 Line 9	720,000	720,000
Apple Health Care	21 Waterville Road Avon, CT	<input type="radio"/>	<input checked="" type="radio"/>		Management & Accounting Services	Pg. 16 Line m12	463,075	463,075
Healthport Services	21 Waterville Road Avon, CT	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg 10/13 schedule	67,413	67,413
Allstar	21 Waterville Road Avon, CT	<input checked="" type="radio"/>	<input type="radio"/>	15%	Therapy Services	Pg. 13 B5/B9/B10	397,311	364,334
Corporate Employee	21 Waterville Road Avon, CT	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	13,589	13,589
Employees @ various Apple Facilities		<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	69,243	69,243
Apple Health Care	21 Waterville Road Avon, CT	<input type="radio"/>	<input checked="" type="radio"/>		Pension Plan (401K)	Pg. 15 1a7	24,753	24,753
Aetna	PO Box 88860 Chicago, IL	<input checked="" type="radio"/>	<input type="radio"/>		Group Medical	Pg. 15 1a5	392,508	
Delta Dental	PO Box 23700 Newark, NJ	<input checked="" type="radio"/>	<input type="radio"/>		Group Dental	Pg. 15 1a5	34,457	

* Use additional sheets if necessary.

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

Annual Report of Long-Term Care Facility

**General Information and Questionnaire
Related Parties***

Name of Facility Westfield Care & Rehab	License No. 980-C	Report for Year Ended 9/30/2015	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Unum Life Insurance	PO Box 406946 Atlanta, GA	X			Group Life & Disability	Pg. 15 1a6	12,229	
Marsh	PO Box 19636 Newark, NJ	X			Property, Liability, & Umbrella Insurance	Pg. 27 14a	86,944	
Medstat	41 Northwest Dr. Plainville, CT	X		9%	Pharmacy	Pg. 13B3/Pg. 20 5a1	203,527	195,386
AIG	PO Box 10472 Newark, NJ	X			Worker's Compensation	Pg. 15 1a1	105,599	
Swallowing Diagnostics	21 Waterville Rd. Avon, CT	X		83%	Diagnostic Services	Pg. 20 5f	3,600	2,736
Brendan Foley	21 Waterville Rd. Avon, CT	X				##		
Ryan Vess	21 Waterville Rd. Avon, CT		X			##		

* Use additional sheets if necessary.

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

Related expense has been disallowed on Pg. 28 Line 23

Westfield

Sep-15

Dept	Name	Amount	Hours
45022 P\S ESP -RN			
	Employee	Amount	Hrs
Oct-14	Libunao	377.50	8.25
	Matthews	2,474.25	59.75
	Massarelli	355.50	8.50
	Indirect	1,078.52	
Dec-14	Poole	303.75	7.25
	Matthews	1,558.50	37.50
	Plantamuro	331.50	8.50
	Buchanan	342.50	8.25
Jan-15	Scanzillo	375.00	9.00
	Matthews	2,172.00	52.00
	Plantamuro	660.50	17.50
	Buchanan	364.50	8.75
	Wortman	365.25	8.75
Feb-15	Indirect	1,219.00	
	Libunao	394.00	8.25
	Poole	313.50	7.50
	Matthews	1,451.25	34.75
	Nyanjong	247.25	5.75
	Buchanan	1,001.00	24.00
Mar-15	Massarelli	722.25	17.75
	Indirect	1,581.00	
	Matthews	730.50	17.50
Apr-15	Plantamuro	321.00	8.25
	Indirect	1,711.00	
Sep-15	Indirect	5,162.00	

45023 P\S ESP -LPN			
	Employee	Amount	Hrs
Oct-14	Stack	128.00	4.00
	varrone	1,938.75	58.75
	Arshad	775.00	25.00
	Pierre	210.25	7.25
	Thomas	511.50	16.50
	Yopp	288.00	9.00
	Lacoss	816.00	25.50
	Suprynowicz	246.50	8.50
	Indirect	1,652.45	
Nov-14	varrone	1,089.00	33.00
	Green	503.75	16.25
	Arshad	255.75	8.25
	Thomas	937.75	30.25

	Sadoski	238.00	8.50
	Raynoso	495.00	16.50
	Suprynowicz	507.50	17.50
	Pinamang	262.50	8.75
	Indirect	2,545.65	
Dec-14	Stack	280.00	8.75
	varrone	816.75	24.75
	Gause	232.00	8.00
	Thomas	488.25	15.75
	Raynoso	495.00	16.50
	Suprynowicz	445.50	16.50
	Alicea	297.00	9.00
Jan-15	varrone	264.00	8.00
	Parker	280.50	8.50
	Lacoss	255.00	8.50
	Alicea	271.25	8.75
	Indirect	461.00	
Feb-15	varrone	569.25	17.25
	Green	272.25	8.25
	Indirect	313.00	
Apr-15	Indirect	339.00	
Sep-15	Indirect	1,023.00	

41001	Administrator	Employee	Facility	Amount	Hrs
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		Cole	Apple	45,318.20	960.00
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41003	Bookkeep	Employee	Facility	Amount	Hrs
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Oct-14	SHR ALLOC	Dimonaco	Coccomo	(162.75)	(7.75)
Nov-14		Dimonaco	Coccomo	(42.00)	(2.00)
Jan-15		Dimonaco	Rocky Hill	(63.00)	(3.00)

41004	Social Service	Employee	Facility	Amount	Hrs
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Oct-14		Dorsey	Chesterfields	(68.25)	(3.00)
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41006	Maint	Employee	Facility	Amount	Hrs
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Dec-14		Scheyd	Cromwell	88.00	8.00
Jan-15		Scheyd	Cromwell	176.00	16.00
Mar-15		Scheyd	Cromwell	79.75	7.25

41007	Projects	Employee	Facility	Amount	Hrs
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Oct-14		Sakowski	Orchard	(456.32)	(25.00)
		Sakowski	Hewitt	(301.12)	(16.50)
		Sakowski	Gardner	(2,240.19)	(122.75)

		Sakowski	Guilford	(59.31)	(3.25)
Nov-14		Sakowski	Gardner	(2,614.30)	(143.25)
Dec-14		Sakowski	Gardner	(1,542.13)	(84.50)
		Sakowski	Farm Valley	(488.19)	(26.75)
		Sakowski	Chesterfields	(647.88)	(35.50)
1/31/2015		Sakowski	Chesterfields	(100.37)	(5.50)
1/31/2015		Sakowski	Farm Valley	(1,179.09)	(64.50)
1/31/2015		Sakowski	Gardner	(1,802.19)	(98.75)
2/28/2015		Sakowski	Gardner	(907.93)	(49.75)
2/28/2015		Sakowski	Farm Valley	(939.87)	(51.50)
2/28/2015		Sakowski	Saybrook	(958.12)	(52.50)
2/28/2015		Sakowski	Rocky Hill	(168.82)	(9.25)
3/31/2015		Sakowski	Farm Valley	(50.19)	(2.75)
3/31/2015		Sakowski	Gardner	(438.02)	(24.00)
3/31/2015		Sakowski	Rocky Hill	(73.00)	(4.00)
3/31/2015		Sakowski	Laurel	(100.38)	(5.50)

45001	RN	Employee	Facility	Amount	Hrs
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Sep-15			Matthews	54.13	1.25
			Matthews	384.75	26.50

45002	LPN	Employee	Facility	Amount	Hrs
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Oct-14		Healey	Avon	254.38	9.25
		Elliot	Watrous	2,396.26	108.00
		Eason	Coccomo	844.00	33.25
Nov-14		Healey	Avon	483.13	17.25
		Elliot	Watrous	408.00	17.00
		Eason	Coccomo	192.13	7.25
Dec-14		Elliot	Watrous	947.75	43.75
		Eason	Coccomo	574.50	22.50
Jan-15		Healey	Avon	1,037.14	37.25
		Eason	Coccomo	331.25	13.25
Feb-15		Healey	Avon	985.26	35.50
		Eason	Coccomo	218.75	8.75
Mar-15		Healey	Avon	242.25	8.50
		Eason	Coccomo	187.50	7.50

45003	CNA	Employee	Facility	Amount	Hrs
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Oct-14		Fuqua	Farm Valley	(206.64)	(23.75)
		Leatherwood	Laurel	93.28	7.00
Nov-14		Edwards	Farm Valley	(232.73)	(26.75)
Dec-14		Edwards	Farm Valley	(843.93)	(97.00)

	45017	MDS	Employee	Facility	Amount	Hrs
10/31/2014			Latronica	Ledgecrest	1,162.30	41.50
11/30/2014			Latronica	Ledgecrest	940.00	33.00
12/31/2014			Latronica	Ledgecrest	679.00	24.25
1/31/2015			Latronica	Ledgecrest	938.00	33.50
2/28/2015			Latronica	Ledgecrest	812.00	28.75
3/31/2015			Latronica	Ledgecrest	259.00	9.25

	50001	Dietician	Employee	Facility	Amount	Hrs
Oct-14			Bighinatti	Farm Valley	1,320.00	44.00
			Dubuque	Mary	224.00	8.00
Nov-14			Rodak	Shelton	137.50	5.50
			Bighinatti	Farm Valley	915.00	30.50
Dec-14			Bighinatti	Farm Valley	1,020.00	34.00
Jan-15			Bighinatti	Farm Valley	1,440.00	48.00
Feb-15			Bighinatti	Farm Valley	1,170.00	39.00
Mar-15			Bighinatti	Farm Valley	270.00	9.00

	50002	Chef	Employee	Facility	Amount	Hrs
Oct-14			Liebe	Colchester	40.25	3.50
			Liebe	Colchester	(203.00)	(18.00)

	50003	Dietary Aids	Employee	Facility	Amount	Hrs
Oct-14			Liebe	Colchester	22.00	2.00

Subtotal

Healthport

Apple

Payroll
Billing unit - 41003
Corporate employees

25,613.02	357.75
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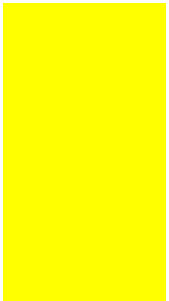
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(68.25)	(3.00)		
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9,102.30 369.00

(1,190.02) (140.50) 10 12 d

4,790.30 170.25

6,496.50 218.00 10 5 a

(162.75) (14.50)

22.00 2.00 10

95,872.86 1,591.75

46,117.12 809.75 Page 4

49,755.74 782.00

2,532.00 81.00

11,057.00 509.00 10 11 b

13,589.00 590.00

63,344.74 1,372.00

20970690 Rivera	Shakeya	# Farmington	# Westfield 918-45003
20970690 Rivera	Shakeya	# Farmington	# Westfield 918-45003
20970690 Rivera	Shakeya	# Farmington	# Westfield 918-45003
20970690 Rivera	Shakeya	# Farmington	# Westfield 918-45003
20970690 Rivera	Shakeya	# Farmington	# Westfield 918-45003
20970690 Rivera	Shakeya	# Farmington	# Westfield 918-45003
20970690 Rivera	Shakeya	# Farmington	# Westfield 918-45003
20970690 Rivera	Shakeya	# Farmington	# Westfield 918-45003

18970333 CASTRO	ASHLEY	# Westfield	# Cocomo 919-45003
18970317 GONZALEZ	MARYAN	# Westfield	# Cocomo 919-45003
18970317 GONZALEZ	MARYAN	# Westfield	# Cocomo 919-45003
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18970097 GRYCZEWSKI	TERESA	# Westfield	# Cocomo 919-45003
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18970358 ROSA	JENNIFER	# Westfield	# Cocomo 919-45003
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18970358 ROSA	JENNIFER	# Westfield	# Cocomo 919-45003
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18006184 SALMON	PRISCILL	# Westfield	# Cocomo 919-45003
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18006184 SALMON	PRISCILL	# Westfield	# Cocomo 919-45003
18006184 SALMON	PRISCILL	# Westfield	# Cocomo 919-45003

21970195 LATRONICA	LORIE	# Ledgecrest	# Westfield 918-45017
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21970195 LATRONICA	LORIE	# Ledgecrest	# Westfield 918-45017
21970195 LATRONICA	LORIE	# Ledgecrest	# Westfield 918-45017
21970195 LATRONICA	LORIE	# Ledgecrest	# Westfield 918-45017

Administrator		1,120.00	54,957.28	
				1,120.00
Salaries - Projects - JobTitle = SPECIAL PROJECTS	4/23/2015	(5.00)	(91.25)	(5.00)
Salaries - R.N. (CCNH) - JobTitle = RN SNF	3/19/2015	50.50	720.75	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	3/26/2015	57.50	1,123.68	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	3/26/2015	42.50	661.00	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	4/2/2015	17.50	341.25	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	4/2/2015	51.50	740.25	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	4/2/2015	77.00	1,026.00	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	4/9/2015	86.00	1,570.25	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	4/16/2015	103.00	1,480.50	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	4/23/2015	33.25	565.50	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	4/23/2015	51.50	743.80	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	4/23/2015	16.50	338.50	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	4/30/2015	8.50	255.00	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	4/30/2015	24.50	345.75	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	4/30/2015	21.50	303.75	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	5/7/2015	24.50	345.75	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	5/14/2015	25.00	355.50	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	5/21/2015	27.50	336.00	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	5/28/2015	25.50	365.25	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	6/11/2015	16.75	347.75	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	6/25/2015	24.50	444.00	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	7/16/2015	16.00	256.00	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	7/16/2015	(26.00)	(314.00)	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	9/10/2015	25.00	355.50	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	9/17/2015	26.00	375.00	
Salaries - R.N. (CCNH) - JobTitle = RN SNF	9/24/2015	25.50	365.25	
			Total	851.50
Salaries LPN - JobTitle = LPN SNF	3/26/2015	17.75	461.50	
Salaries LPN - JobTitle = LPN SNF	4/9/2015	9.25	240.50	
Salaries LPN - JobTitle = LPN SNF	4/16/2015	9.00	234.00	
Salaries LPN - JobTitle = LPN SNF	4/23/2015	9.00	234.00	
Salaries LPN - JobTitle = LPN SNF	5/7/2015	9.25	240.50	
Salaries LPN - JobTitle = LPN SNF	6/11/2015	9.75	253.50	
Salaries LPN - JobTitle = LPN SNF	6/18/2015	9.75	253.50	
Salaries LPN - JobTitle = LPN SNF	7/2/2015	8.50	221.00	
Salaries LPN - JobTitle = LPN SNF	7/9/2015	19.50	507.00	
Salaries LPN - JobTitle = LPN SNF	7/16/2015	17.75	461.50	
Salaries LPN - JobTitle = LPN SNF	7/30/2015	10.00	260.00	
Salaries LPN - JobTitle = LPN SNF	8/6/2015	8.50	221.00	
Salaries LPN - JobTitle = LPN SNF	9/10/2015	8.50	212.50	

Salaries LPN - JobTitle = LPN SNF	7/2/2015	16.50	379.50
Salaries LPN - JobTitle = LPN SNF	3/19/2015	36.75	753.19
Salaries LPN - JobTitle = LPN SNF	3/26/2015	8.25	206.25
Salaries LPN - JobTitle = LPN SNF	4/2/2015	8.25	206.25
Salaries LPN - JobTitle = LPN SNF	5/21/2015	7.25	181.25
Salaries LPN - JobTitle = LPN SNF	5/28/2015	8.00	200.00
Salaries LPN - JobTitle = LPN SNF	6/4/2015	14.50	192.13
Salaries LPN - JobTitle = LPN SNF	6/18/2015	9.25	231.25
Salaries LPN - JobTitle = LPN SNF	6/25/2015	16.25	406.25
Salaries LPN - JobTitle = LPN SNF	7/16/2015	24.25	606.25
Salaries LPN - JobTitle = LPN SNF	7/23/2015	8.50	212.50
Salaries LPN - JobTitle = LPN SNF	7/30/2015	16.75	418.75
Salaries LPN - JobTitle = LPN SNF	8/20/2015	8.75	218.75
Salaries LPN - JobTitle = LPN SNF	8/27/2015	23.75	578.17
Salaries LPN - JobTitle = LPN SNF	9/3/2015	8.25	206.25
Salaries LPN - JobTitle = LPN SNF	8/20/2015	22.50	347.54
Salaries LPN - JobTitle = LPN SNF	9/10/2015	15.50	240.25
Salaries LPN - JobTitle = LPN SNF	9/24/2015	17.00	280.50
Salaries LPN - JobTitle = LPN SNF	5/21/2015	8.00	112.00
Salaries LPN - JobTitle = LPN SNF	6/11/2015	8.00	248.00
Salaries LPN - JobTitle = LPN SNF	6/18/2015	8.00	248.00
Salaries LPN - JobTitle = LPN SNF	7/23/2015	17.00	255.00
Salaries LPN - JobTitle = LPN SNF	8/6/2015	5.00	155.00
Salaries LPN - JobTitle = LPN SNF	8/13/2015	16.50	272.25
Salaries LPN - JobTitle = LPN SNF	3/19/2015	4.50	126.00
Salaries LPN - JobTitle = LPN SNF	4/16/2015	18.00	270.00
Salaries LPN - JobTitle = LPN SNF	5/21/2015	17.00	255.00
Salaries LPN - JobTitle = LPN SNF	5/28/2015	16.00	240.00
Salaries LPN - JobTitle = LPN SNF	6/4/2015	8.50	238.00
Salaries LPN - JobTitle = LPN SNF	6/11/2015	8.25	231.00
Salaries LPN - JobTitle = LPN SNF	8/27/2015	8.25	231.00
Salaries LPN - JobTitle = LPN SNF	6/11/2015	8.00	240.00
Salaries LPN - JobTitle = LPN SNF	5/21/2015	15.50	248.00
Salaries LPN - JobTitle = LPN SNF	6/4/2015	17.00	272.00
Salaries LPN - JobTitle = LPN SNF	8/13/2015	16.50	264.00
Salaries LPN - JobTitle = LPN SNF	6/11/2015	8.75	236.25
Salaries LPN - JobTitle = LPN SNF	7/9/2015	16.50	255.75
Salaries LPN - JobTitle = LPN SNF	4/9/2015	18.50	305.25
Salaries LPN - JobTitle = LPN SNF	4/23/2015	17.00	280.50
Salaries LPN - JobTitle = LPN SNF	5/21/2015	16.00	264.00
Salaries LPN - JobTitle = LPN SNF	5/28/2015	50.50	833.25
Salaries LPN - JobTitle = LPN SNF	6/11/2015	18.50	305.25
Salaries LPN - JobTitle = LPN SNF	7/9/2015	17.00	280.50

Total 779.50

Salaries - Aides - JobTitle = CNA SNF	6/25/2015	32.00	216.00
Salaries - Aides - JobTitle = CNA SNF	7/2/2015	66.00	334.13
Salaries - Aides - JobTitle = CNA SNF	7/9/2015	48.75	223.44
Salaries - Aides - JobTitle = CNA SNF	7/16/2015	16.50	107.25
Salaries - Aides - JobTitle = CNA SNF	7/23/2015	40.00	214.00
Salaries - Aides - JobTitle = CNA SNF	7/30/2015	57.25	324.70
Salaries - Aides - JobTitle = CNA SNF	8/6/2015	32.50	211.25
Salaries - Aides - JobTitle = CNA SNF	9/17/2015	40.75	217.44
Salaries - Aides - JobTitle = CNA SNF	9/24/2015	40.75	217.44

374.50

Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/2/2015	-2	(22.50)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/2/2015	-4	(26.00)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/16/2015	-4	(26.00)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/23/2015	-2	(24.50)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/30/2015	-2	(24.50)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	5/7/2015	-1.75	(21.44)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/2/2015	-4	(25.74)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/9/2015	-4	(25.74)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/16/2015	-4	(25.74)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/23/2015	-4	(25.74)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/30/2015	-2	(24.24)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	5/7/2015	-4	(38.75)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/2/2015	-2	(28.10)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/16/2015	-2	(28.10)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/23/2015	-2.75	(33.47)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/30/2015	-2	(28.10)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	5/7/2015	-2.75	(35.19)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/2/2015	-4	(24.00)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/9/2015	-4	(24.00)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/23/2015	-2.25	(25.31)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/2/2015	-2	(22.00)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/9/2015	-2	(22.00)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/16/2015	-2	(22.00)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/23/2015	-2	(22.00)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/30/2015	-1.75	(19.25)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	5/7/2015	-1.75	(19.25)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/2/2015	-2.25	(29.88)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/9/2015	-4	(28.06)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/16/2015	-2	(26.56)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/23/2015	-2.25	(29.88)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	4/30/2015	-2	(26.56)
Salaries - Aides - JobTitle = CNA CAREER PATH LEVE	5/7/2015	-4	(28.06)

(87.50)

Salaries - MDS Coordinator - JobTitle = MDS COORDIN.	5/7/2015	9.50	266.00
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Salaries - MDS Coordinator - JobTitle = MDS COORDIN. 5/14/2015	8.75	245.00	
Salaries - MDS Coordinator - JobTitle = MDS COORDIN. 5/21/2015	8.75	245.00	
Salaries - MDS Coordinator - JobTitle = MDS COORDIN. 5/28/2015	9.50	266.00	36.50
			3,069.50

54,957.28

(91.25)

13,447.98

16,331.53

2,065.65

(832.66)

1,022.00

86,900.53

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Westfield Care & Rehab	License No. 980-C	Report for Year Ended 9/30/2015	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

N/A

General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility Westfield Care & Rehab			License No. 980-C		Report for Year Ended 9/30/2015		Page 6	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input checked="" type="radio"/> Yes <input type="radio"/> No	Total ***

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

General Information and Questionnaire
Accounting Basis

Name of Facility Westfield Care & Rehab	License No. 980-C	Report for Year Ended 9/30/2015	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:
 Accrual Cash Modified Cash

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

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

1 Preparation of audited financials (dissallow Pg. 28)	\$ 4,842
2 Preparation of tax returns	\$ 2,025
3	\$
4	\$
	Charge for Services Provided
	\$ 6,867

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

Legal Services Information

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

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

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

Services Provided by This Firm (*describe fully*)

1 Collection litigation	\$ 1,362
2 Appointment of Conservator	\$ 323
3 Appointment of Conservator	\$ 528
4 Filing fees	\$ 360
5	\$
	Charge for Services Provided
	\$ 2,573

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

Schedule of Resident Statistics

Name of Facility Westfield Care & Rehab			License No. 980-C			Report for Year Ended 9/30/2015				Page 8		of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	100	100			100	100			100	100			
B. On last day of THIS report period	100	100			100	100			100	100			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	78	78			78	78			78	78			
B. As of midnight of THIS report period	86	86			86	86			86	86			
3. Total Number of Days Care Provided During Period													
A. Medicare	3,804	3,804			2,919	2,919			885	885			
B. Medicaid (Conn.)	23,443	23,443			17,296	17,296			6,147	6,147			
C. Medicaid (other states)													
D. Private Pay	2,654	2,654			2,066	2,066			588	588			
E. State SSI for RCH													
F. Other (Specify)													
G. Total Care Days During Period (3A thru F)	29,901	29,901			22,281	22,281			7,620	7,620			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days													
B. Other Bed Reserve Days													
5. Total Resident Days (3G + 4A + 4B)	29,901	29,901			22,281	22,281			7,620	7,620			

Schedule of Resident Statistics (Cont'd)

Name of Facility Westfield Care & Rehab			License No. 980-C			Report for Year Ended 9/30/2015			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days									CCNH	RHNS	(Specify)		
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	4		64		18								
Per Diem Rate													
a. One bed rm.					434.00								
b. Two bed rms.	RUGS III		200.00		387.00								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									2,107	2,107			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									8,126	8,126			
D. Total Physical Therapy Treatments									10,233	10,233			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									557	557			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									737	737			
D. Total Speech Therapy Treatments									1,294	1,294			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									1,617	1,617			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									7,892	7,892			
D. Total Occupational Therapy Treatments									9,509	9,509			

Report of Expenditures - Salaries & Wages

Name of Facility Westfield Care & Rehab	License No. 980-C	Report for Year Ended 9/30/2015	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	104,113	2,018				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	40,548	2,545				
5. Dietary Service						
a. Head Dietitian	6,799	218				
b. Food Service Supervisor	45,516	2,087				
c. Dietary Workers	203,260	20,905				
6. Housekeeping Service						
a. Head Housekeeper	17,956	928				
b. Other Housekeeping Workers	119,749	11,608				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	105,045	6,166				
8. Laundry Service						
a. Supervisor	23,228	1,191				
b. Other Laundry Workers	47,201	4,564				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants	116,636	4,901				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	156,837	4,169				
b. RN						
1. Direct Care	359,575	20,887				
2. Administrative**	136,746	4,407				
c. LPN						
1. Direct Care	716,932	43,174				
2. Administrative**						
d. Aides and Attendants	1,074,176	106,782				
e. Physical Therapists	13,472	1,002				
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	82,670	4,693				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	90,537	3,887				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	3,460,992	246,132				

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

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

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

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

Name of Facility				License No.	Report for Year Ended				Page	of
Westfield Care & Rehab				980-C	9/30/2015				11	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
Westfield Care & Rehab				980-C	9/30/2015			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Renee Cole	104,113				Administrator 10/1/14 - 9/30/15	2,018	A 2			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Westfield Care & Rehab	980-C	9/30/2015	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary						
(For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	9,612	275				
3. Pharmacist	6,891	197				
4. Podiatrist	139	4				
5. Physical Therapy						
a. Resident Care	174,470	2,558				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	18,780	118				
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) PointRight, misc Physicians	2,868	38				
9. Speech Therapist						
a. Resident Care	63,409	324				
b. Other						
10. Occupational Therapist						
a. Resident Care	159,432	2,377				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	25,613	358				
2. Administrative***						
b. LPN						
1. Direct Care	20,504	452				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	481,719	6,701				

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

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

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

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

Name of Facility Westfield Care & Rehab		License No. 980-C	Report for Year Ended 9/30/2015	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Allstar Therapy 21 Waterville Rd. Avon, CT	Therapy Services	<input checked="" type="radio"/>	<input type="radio"/>	See Disclosure Pg. 4	
Healthport Services 21 Waterville Rd. Avon, CT	Employee Staffing	<input checked="" type="radio"/>	<input type="radio"/>	See Disclosure Pg. 4	
Medstat 41 Northwest Dr. Plainville, CT	Pharmacist	<input checked="" type="radio"/>	<input type="radio"/>	See Disclosure Pg. 4	
Joseph Tomanelli Meriden CT	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Healthdrive 25 Needham St Newton MA	Dentist and Podiatrist	<input type="radio"/>	<input checked="" type="radio"/>		
Cardiology Assoc of Central CT	Cardiologist	<input type="radio"/>	<input checked="" type="radio"/>		
Comprehensive Ortho	Orthodontist	<input type="radio"/>	<input checked="" type="radio"/>		
CT Neurological Specialist	Neurologist	<input type="radio"/>	<input checked="" type="radio"/>		
Eye Physicians of Central CT	Eye Doctor	<input type="radio"/>	<input checked="" type="radio"/>		
Sergio Francescon, MD	Dermatologist	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Westfield Care & Rehab	980-C	9/30/2015		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 105,599	105,599			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 65,591	65,591			
4. Social Security (F.I.C.A.)	\$ 246,464	246,464			
5. Health Insurance	\$ 309,603	309,603			
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 12,229	12,229			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 24,753	24,753			
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>) See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 305,788	305,788			
d. Accounting and Auditing	\$ 6,867	6,867			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 2,573	2,573			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 17,109	17,109			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 17,005	17,005			
2. Cellular Phones	\$				
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$				
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (<i>Specify</i>) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 586,710	586,710			
Subtotal	\$ 1,700,291	1,700,291			

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended		Page	of
Westfield Care & Rehab	980-C	9/30/2015		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:		1,700,291	1,700,291		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$ 6,593	6,593			
2. Holiday Parties for Staff	\$ 6,017	6,017			
3. Gifts to Staff and Residents	\$ 9,697	9,697			
4. Employee Travel	\$ 10,206	10,206			
5. Education Expenses Related to Seminars and Conventions	\$ 2,536	2,536			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 207	207			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 6,385	6,385			
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 3,825	3,825			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 6,924	6,924			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 633	633			
9. Subscriptions	\$ 824	824			
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$				
12. Administrative Management Services**	\$ 463,075	463,075			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 66,020	66,020			
C-14 Total Administrative & General Expenditures	\$ 2,283,233	2,283,233			

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Advertising - Public Relations	\$ 6,385		
Total Other Advertising	\$ 6,385	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 6,824		
Mariter Perez	\$ 100		
Total Dues	\$ 6,924	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Corporate Fees - Non Reimbursable	\$ 36,105		
Licenses & Fees	\$ 3,135		
Pre Employment Screening	\$ 7,780		
Point Click Care Fees	\$ 10,595		
Bank Charges	\$ 66		
Resident Expenses	\$ 331		
Account Write Off	\$ 4,641		
User fee audit - 2011-2013	\$ 3,367		
Total Other Administrative and General	\$ 66,020	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Westfield Care & Rehab	License No. 980-C	Report for Year Ended 9/30/2015	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Apple Health Care, Inc.	463,075	Accounting & Managerial Services	Pg. 16 m12

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Westfield Care & Rehab	980-C	9/30/2015	18	37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 212,517	212,517		
2. Non-Food Supplies	\$ 46,648	46,648		
3. Other (Specify) _____	\$ _____			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 1,319	1,319		
c. Management Services**	\$ _____			
d. Other (Specify) _____	\$ _____			
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 260,484	260,484		
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*	245	245		
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No				
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.				
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.				
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility Westfield Care & Rehab		License No. 980-C	Report for Year Ended 9/30/2015	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. \$	16,682	16,682	
2.	Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.			
		Amt. \$			
3.	Personal clothing of residents washed, ironed, and/or processed.***	Lbs.			
		Amt. \$			
4.	Repair and/or purchase of linens.***	Lbs.			
		Amt. \$	10,347	10,347	
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)		\$	27,029	27,029	
3F. Laundry Questionnaire					
G.	Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
H.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
I.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
L.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of	
Westfield Care & Rehab	980-C	9/30/2015	20	37	
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care					
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	40,091	40,091		
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. Management Services*	\$				
d. Other (<i>Specify</i>)	\$				
4E. Total Housekeeping Expenditures (4a + b + c + d)	\$	40,091	40,091		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Medstat , West River	\$	141,352	141,352		
b. Medicine Cabinet Drugs	\$				
c. Medical and Therapeutic Supplies	\$	237,328	237,328		
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	40,957	40,957		
f. X-rays and Related Radiological Procedures***	\$	14,611	14,611		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	11,999	11,999		
i. Recreation	\$	24,710	24,710		
j. Other (Specify)**** See Attached Schedule	\$	39,133	39,133		
5K. Total Resident Care Expenditures (5a - 5j)	\$	510,090	510,090		

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

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

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

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

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

Name of Facility Westfield Care & Rehab			License No. 980-C		Report for Year Ended 9/30/2015				Page of 21 37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
CWPM	25 Norton Pl Plainville CT	<input type="radio"/>	<input checked="" type="radio"/>		Refuse Removal	25,610			22	6 f
Perfectemp	635 Old Turnpike Rd Plantsville, CT	<input type="radio"/>	<input checked="" type="radio"/>		Heating \ Cooling	28,515			22	6 a
Roy's Landscaping	PO Box 224 Portland CT	<input type="radio"/>	<input checked="" type="radio"/>		Snow removal	12,762			22	6 a
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							

* 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 Westfield Care & Rehab	License No. 980-C	Report for Year Ended 9/30/2015			Page 22	of 37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 147,038	147,038				
b. Heat	\$ 54,667	54,667				
c. Light & Power	\$ 64,609	64,609				
d. Water	\$ 27,457	27,457				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$					
f. Other (<i>itemize</i>)	\$ 29,169	29,169				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 322,940	322,940				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$ 434	434				
d. Movable Equipment	\$ 13,825	13,825				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 14,259	14,259				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 27,554	27,554				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 27,554	27,554				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 720,000	720,000				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 55,587	55,587				
c. Personal property taxes	\$ 3,692	3,692				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 821,092	821,092				

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

Westfield Care & Rehab
9/30/2015

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

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

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Non-Movable Equipment		\$ -		\$ - *
Deletions:				
7/1/1988	SNET (PHONE SYSTEM)	\$ (9,621)	NME-10	
11/1/2003	ice machine motor (HiPoint Heating and C	\$ (2,340)	NME-10	
Total deletions for Non-Movable Equipment		\$ (11,962)		\$ - **

*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:				
10/1/2014	WASHER REBUILT 50# CAP (DANIELS)	\$ 6,700	ME-8	\$ 1,047
12/1/2014	CONVECTION STEAMER (DIRECT SUPPLY)	\$ 4,754	ME-10	\$ 594
2/20/2015	INFRASTRUCTURE CONFIGURATION (JKS)	\$ 44	ME-5	\$ 3
3/4/2015	INFRASTRUCTURE CONTROLLERS (JKS)	\$ 1,183	ME-5	\$ 82
3/5/2015	INFRASTRUCTURE (JKS)	\$ 884	ME-5	\$ 62
3/19/2015	Payroll System Upgrade-Time Clocks	\$ 1,233	ME-10	\$ 42
3/19/2015	Payroll System Upgrade-Time Clocks	\$ 1,196	ME-10	\$ 41
4/1/2015	15 High Back Chairs(Medline)	\$ 4,467	ME-15	\$ 99
Total additions for Movable Equipment		\$ 20,461		\$ 1,970
Deletions:				
12/1/1989	COLONY (SNOWBLOWER)	\$ (1,026)	ME-8	
12/1/1991	DASH MANU(CUBCLE CRTAINS)	\$ (8,191)	ME-5	
2/1/1992	DASH MANU(CUBCLE CRTAINS)	\$ (491)	ME-5	
2/1/1993	Norhest(Copier)	\$ (1,478)	ME-5	
7/1/2002	install hand scanner (Precision Electric	\$ (700)	ME-10	
4/1/2008	photocopier (Advanced Copy)	\$ (11,046)	ME-5	
4/1/2008	2 laptops (PC Connection)	\$ (1,173)	ME-5	
10/1/2008	photocopier 2nd pmt (Advanced Copy)	\$ (663)	ME-5	
Total deletions for Movable Equipment		\$ (24,768)		\$ -

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/1/2014	DUMBWAITER REPAIR (OTIS)	\$ 2,637	LHI-20	\$ 659
12/1/2014	KITCHEN HOOD FILTERS (ROYBAL & SON)	\$ 854	LHI-10	\$ 107
1/6/2015	WALLS PAINT (THKEIFER)	\$ 561	LHI-5	\$ 42
Total additions for Leasehold Improvement		\$ 4,052		\$ 808
Deletions:				
3/1/1989	BOYLE (PAINT)	\$ (82)	LHI-10	
7/1/1989	BOYLE (PAINT)	\$ (38)	LHI-10	
7/1/1989	BOYLE (PAINT)	\$ (91)	LHI-10	
8/1/1989	BOYLE (PAINT)	\$ (91)	LHI-10	
8/1/1989	BOYLE (PAINT)	\$ (91)	LHI-10	
11/1/1989	BOYLE (PAINT)	\$ (70)	LHI-10	
11/1/1989	VICTOR RON (CURTAINS)	\$ (383)	LHI-10	
11/1/1989	VICTOR RON (DRAPES)	\$ (500)	LHI-10	
12/1/1989	JOHN BOYLE (PAINT/LATEX)	\$ (70)	LHI-5	
2/1/1992	DASH MANUF(CUBICLE CURTAINS)	\$ (83)	LHI-5	
8/1/1992	J. M. BENSON, INC (CARPET)	\$ (2,500)	LHI-5	
9/1/1992	BENSON (CARPET)	\$ (1,309)	LHI-5	
9/1/1992	BENSON (CARPET)	\$ (11,487)	LHI-5	
12/1/1992	Maharam(Curtain Shades)	\$ (169)	LHI-5	
12/1/1992	Maharam(Curtains & Drapes)	\$ (133)	LHI-5	
12/1/1992	Benson(Carpet)	\$ (494)	LHI-5	
Total deletions for Leasehold Improvement		\$ (17,590)		\$ -

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility

Amortization Schedule*

Name of Facility			License No.		Report for Year Ended			Page	of
Westfield Care & Rehab			980-C		9/30/2015			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.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period				1,069,977	878,382	A		26,746	
2. Disposals (attach schedule)				(17,590)					
3. Acquired during this report period (attach schedule)				4,052				808	
C-4. Subtotal									27,554
D. Total Amortization									27,554

* 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 Westfield Care & Rehab	License No. 980-C	Report for Year Ended 9/30/2015	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description	Total				
1. Date Land Purchased					
2. Date Structure Completed					
3. If NOT Original Owner, Date of Purchase					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	100				
6. Square Footage					
7. Acquisition Cost					
a. Land					
b. Building					
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)					
b. Date Mortgage Obtained					
c. Interest Rate for the Cost Year					
d. Term of Mortgage (number of years)					
e. Amount of Principal Borrowed		See Attached			
f. Principal balance outstanding as of _____					
Complete if Mortgage was Refinanced During Current Cost Year					
g. Type of Financing (e.g., fixed, variable)					
h. Date of Refinancing					
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed					
l. Principal Outstanding on Note Paid-Off					
Part C - Arms-Length Leases for Real Property Improvements Only					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	

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

CT Medicaid Cost Report Attachment Page 25

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

Note: The following facilities are collateralized by this mortgage.

Connecticut Facilities

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

Out of State Facilities

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

6 Month extension

extension to 10/13/15

2.08%

6 month

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

Name of Facility		License No.	Report for Year Ended		Page	of
Westfield Care & Rehab		980-C	9/30/2015		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended	Page	of		
Westfield Care & Rehab	980-C	9/30/2015	27	37		
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment \$						
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify) \$						
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) \$						
12. D. Other Interest Expense (Specify) \$ 5,159 5,159						
Value settlement \$4,662 , Late pmt int \$497						
13. Total All Interest Expense (12B7 + 12C3 + 12D) \$ 5,159 5,159						
14. Insurance						
a. Insurance on Property (buildings only) \$ 86,944 86,944						
b. Insurance on Automobiles \$						
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage) \$						
2. Fire and Extended Coverage \$						
3. Other (Specify) \$						
14d. Total Insurance Expenditures (14a + b + c) \$ 86,944 86,944						
15. Total All Expenditures (A-13 thru C-14) \$ 8,299,774 8,299,774						

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Westfield Care & Rehab				980-C	9/30/2015	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 4,010	4,010		
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$ 159,432	159,432		
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 305,788	305,788		
10.	15	1d/e	Accounting & Legal	\$ 6,204	6,204		
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m2/3	Unallowable Advertising *	\$ 6,385	6,385		
19.			Income Tax / Corporate Business Tax	\$			
20.	16	m10	Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 51,472	51,472		
Page 18 - Dietary Expenditures							
24.	30	IV1	Meals to employees, guests and others who are not residents	\$			
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 533,292	533,292		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	12m	Social Service/Marketing	\$ 4,010		
Total Other Salaries Adjustment			\$ 4,010	\$ -	\$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Corporate Fee - Non Reimburable	\$ 36,105		
16	1.3	Employee Recognition/Gifts/Parties	\$ 9,697		
16	8a	Chamber of Commerce	\$ 633		
16	m13	Bank Charges	\$ 66		
16	m13	Resident Expenses	\$ 331		
16	m13	Account Write Off	\$ 4,641		
Total Other A&G Adjustments			\$ 51,472	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Westfield Care & Rehab			980-C	9/30/2015	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 533,292	533,292		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 141,352	141,352		
28.	16	L1	Ambulance/Limousine	\$ 6,593	6,593		
29.	20	h	X-rays, etc	\$ 14,611	14,611		
30.	20	f	Laboratory	\$ 11,999	11,999		
31.			Medical Supplies	\$			
32.	20	5e2	Oxygen (non emergency)	\$ 34,103	34,103		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 32,689	32,689		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Research or Experimental Activities	\$			
43.	30	IV4	Radio and Television Revenue	\$ 5,146	5,146		
44.			Vending Machine Revenue	\$			
45.	30	IV8	Purchase Discounts and Allowances	\$ 26,062	26,062		
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	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$ 6,001	6,001		
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)			\$ 811,848	811,848		

*** 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.

Westfield Care & Rehab
9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	IV Therapy Supplies	\$ 32,689		
20	5j	Rehab Service Supplies	\$ -		
Total Other Ancillary Costs			\$ 32,689	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
var	var	Outpatient disallowance	\$ 842		
27	12 d	Value settlement \$4,662 , Late pmt int \$497	\$ 5,159		
Total Other Adjustments			\$ 6,001	\$ -	\$ -

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
Westfield Care & Rehab	980-C	9/30/2015			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 4,324,142	4,324,142				
b. Medicaid Room and Board Contractual Allowance **	\$					
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 780,850	780,850				
b. Medicare Room and Board Contractual Allowance **	\$ 240,473	240,473				
4. a. Private-Pay Residents and Other	\$ 1,848,140	1,848,140				
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 82,155	82,155				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (82,155)	(82,155)				
c. Prescription Drugs - Non-Medicare	\$ 66,310	66,310				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (54,886)	(54,886)				
2. a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$ 241,711	241,711				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (173,267)	(173,267)				
c. Physical Therapy - Non-Medicare	\$ 116,430	116,430				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (114,870)	(114,870)				
4. a. Speech Therapy - Medicare	\$ 46,756	46,756				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (23,492)	(23,492)				
c. Speech Therapy - Non-Medicare	\$ 11,475	11,475				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (11,475)	(11,475)				
5. a. Occupational Therapy - Medicare	\$ 293,086	293,086				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (225,552)	(225,552)				
c. Occupational Therapy - Non-Medicare	\$ 134,820	134,820				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (134,820)	(134,820)				
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$ 269	269				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 7,366,099	7,366,099				
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$ 2,010	2,010				
4. Rental of Television and Cable Services	\$ 5,146	5,146				
5. Interest Income (<i>Specify</i>)	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 26,062	26,062				
V. Total Other Revenue (1 thru 8)	\$ 33,218	33,218				
VI. Total All Revenue (III +V)	\$ 7,399,317	7,399,317				

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30 B 7	Private oxygen	\$ 269		
Total Other Resident Revenue		\$ 269	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30 IV 5	Interest Income	1,072,987	\$ -		
Total Interest Income			\$ -	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV 8	Rebates	\$ 26,062		
Total Other Revenue		\$ 26,062	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Westfield Care & Rehab	980-C	9/30/2015	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	300
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,072,987
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	14,185
5. Prepaid Expenses			\$	5,068
a. Prepaid Insurance	5,068			
b. Prepaid Property Tax				
c. Prepaid Other				
d.				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	
Due Affiliate (Debit Balance)				
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,092,540
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
4. Leasehold Improvements	*Historical Cost <u>1,056,438</u>		\$	150,502
	Accum. Depreciation <u>905,936</u>	Net		
5. Non-Movable Equipment	*Historical Cost <u>23,637</u>		\$	
	Accum. Depreciation <u>23,637</u>	Net		
6. Movable Equipment	*Historical Cost <u>344,198</u>		\$	37,221
	Accum. Depreciation <u>306,976</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
Construction in Progress				
Fixed Asset Clearing Account				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	187,724

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Westfield Care & Rehab	980-C	9/30/2015	32	37
Account			Amount	
Total Brought Forward:			\$	1,280,264
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Non-Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
5. Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
6. Motor Vehicles				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	1,875
	Capitalized Refinance Expense	1,875		

D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	1,875
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	1,282,139

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

G. Balance Sheet (cont'd)

Name of Facility Westfield Care & Rehab		License No. 980-C	Report for Year Ended 9/30/2015	Page 34	of 37
Account				Amount	
Total Brought Forward:				1,302,044	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					
\$					
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$ 1,183,995	
Name and Address of Lender	Amount	Loan Date			
Brian J. Foley	1,183,995	Demand			
4. Other Long-Term Liabilities (<i>itemize</i>)				\$	
Security Deposit					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 1,183,995	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 2,486,039	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Westfield Care & Rehab	980-C	9/30/2015	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	6,503,855
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(6,808,298)
6. Gain or Loss for Period			\$	(900,456)
	10/1/2014	thru	9/30/2015	
7. Total Net Worth			\$	(1,203,900)
C. Total Reserves and Net Worth			\$	(1,203,900)
D. Total Liabilities, Reserves, and Net Worth			\$	1,282,139

H. Changes in Total Net Worth

Name of Facility Westfield Care & Rehab	License No. 980-C	Report for Year Ended 9/30/2015	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2014			\$	(523,746)
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	7,399,317
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	8,299,774
D. Net Income or Deficit			\$	(900,456)
E. Balance			\$	(1,424,202)
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
Capital contributions	225,000			
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	225,000
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	4,698
Name and Address (<i>No., City, State, Zip</i>)	Title	Amount		
Brian Foley	President	4,698		
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose	Amount			
3. Total Deductions			\$	4,698
H. Balance at End of Period			\$	(1,203,900)

I. Preparer's/Reviewer's Certification

Name of Facility Westfield Care & Rehab	License No. 980-C	Report for Year Ended 9/30/2015	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Robert Gwizdak				
Address Address			Phone Number	
21 Waterville Road Avon, CT 06001			(860) 470-7535	

Error Check

Level	Item	Reported as	
	Page 10 - Administrator Hours	2,018	is inconsistent with page 12 of 2,018