State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2016

Name of Facility (as licensed) Brookview Corporation d/b/a West Hartford Health & Rehabilitation Center		
Address (No. & Street, City, State, Zip Code) 130 Loomis Drive, West Hartford, CT 06107		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	1057-C			07-5278

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	1057-C		

For Department Use Only

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

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General Information

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Brookview Corporation d/b/a West Hartford Health &	1057-C	9/30/2016	1	37

Administrator's/Owner's Certification

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

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

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

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.

{a} Subject to Desk Audit Review

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Theresa Sanderson			Printed Name (Owner) Russell Schwartz	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Brookview Corporation d/b/a West Hartford Health & Rehabilitation Center	Period Covered:		From 10/1/2015	To 9/30/2016
Address of Facility 130 Loomis Drive, West Hartford, CT 06107				
Report Prepared By Marcum LLP	Phone Number 203-781-9600		Date 1/13/2017	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-521-8700	9/30/2016	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Brookview Corporation d/b/a West Hartford Health & Rehabil	130 Loomis Drive, West Hartford, CT 06107

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	1057-C			07-5278

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
Theresa Sanderson		001457

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

Name	License No.:
N/A	

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General Information and Questionnaire
Partners/Members

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

Name of Partners/Members	Business Address	Title	% Owned
N/A			

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Brookview Corporation d/b/a West Hartford	1057-C	9/30/2016	3A	37

If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Brookview Corporation	130 Loomis Drive, West Hartford, CT 06107	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Leonard Schwartz	130 Loomis Drive, West Hartford, CT 06107	Stockholder	100
Freda Schwartz	130 Loomis Drive, West Hartford, CT 06107	Pres / Secretary	
Russell Schwartz	130 Loomis Drive, West Hartford, CT 06107	VP / Treasurer	
Names of Stockholders Owning at Least 10% of Shares			
Leonard Schwartz	130 Loomis Drive, West Hartford, CT 06107	Stockholder	100

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Brookview Corporation d/b/a West Hartford Health	1057-C	9/30/2016	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Brookview Corporation d/b/a West Hartford Health & I	1057-C	9/30/2016	4	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ⊙ Yes ○ 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	%**				
Russell Schwartz	130 Loomis Drive, West Hartford, CT 06107	○	⊙		Administrative Support	Pg. 16 / Line m11	185,027	185,027
Brookview Manor Associates, LLC	130 Loomis Drive, West Hartford, CT 06107	○	⊙		Depreciation (Non-movable Equipment)	Pg. 22 / Line 7c	11,704	11,704
Brookview Manor Associates, LLC	130 Loomis Drive, West Hartford, CT 06107	○	⊙		Depreciation (Movable Equipment)	Pg. 22 / Line 7d	55,128	55,128
Brookview Manor Associates, LLC	130 Loomis Drive, West Hartford, CT 06107	○	⊙		Depreciation (Leasehold Equipment)	Pg. 22 / Line 8c	97,268	97,268
Brookview Manor Associates, LLC	130 Loomis Drive, West Hartford, CT 06107	○	⊙		Mortgage Amortization	Pg. 22 / Line 8b		
Leonard Schwartz	130 Loomis Drive, West Hartford, CT 06107	○	⊙		Salary (Distributions)	Pg. 36 / Line G1		
Brookview Manor Associates, LLC	130 Loomis Drive, West Hartford, CT 06107	○	⊙		Rental of Real Property	Various see attached	710,702	710,702
		○	○					
		○	○					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

1. In the preparation of this Report, were all costs allocated as required? ⊙ Yes ○ No

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

N/A

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

The facility allocates the cost of the Director of Operations (Russell Schwartz) salary and shared insurances based upon beds. This split represents 57% being allocated to West Hartford Health Care and 43% to Avon Convalescent Home.

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

⊙ Yes ○ No

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

N/A

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General Information and Questionnaire
Leases (Excluding Real Property)

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

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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
CIT Tech 4600 Touchton Road, Bldg 100, Suite 300 Jacksonville, FL 32099	○	◉	Copier	05/27/15	63 Months	18,117	18,117
Neopost New England 3 Metals Drive, Southington, CT 06489	○	◉	Postage Machine	02/03/11	63 Months	1,439	1,439
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ○ No **Total ***** 19,556

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

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
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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	Cornerstone Accounting	PO Box 182, Plainville, CT 06062
2	Cohn Reznick	180 Glastonbury Blvd, Glastonbury, CT 06033
3	Marcum LLP	555 Long Wharf Drive, New Haven, CT 06511
4		

Services Provided by This Firm (*describe fully*)

1	Month end closing and reconciliation	$ 11,450
2	Tax returns	$ 11,600
3	Cost reports, HUD audit	$ 24,240
4		$
	Charge for Services Provided	$ 47,290

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	Telephone Number
1	Jackson Lewis	914-328-0404
2	Murtha Cullina Richter	860-240-6000
3	Shipman, Sosensky	860-606-1700
4	Various	Various
5		

	Address (*No. & Street, City, State, Zip Code*)
1	One North Broadway, White Plains, NY 10601
2	185 Asylum Street, Hartford, CT 06103-3469
3	20 Batterson Park Road, Farmington, CT 06032
4	Various
5	

Services Provided by This Firm (*describe fully*)

1	Labor Attorney	$ 37,958
2	General Matters & Collections ($6,752 Disallowed on Pg. 28)	$ 10,519
3	Corporate Matters	$ 413
4	Conservatorship & Marshall Fee (Disallowed on Pg. 28)	$ 726
5		$
	Charge for Services Provided	$ 49,616

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

⊙ Yes ○ No — Page 15, Line 1e

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Schedule of Resident Statistics

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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	160	160			160	160			160	160		
B. On last day of THIS report period	160	160			160	160			160	160		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	135	135			135	135			137	137		
B. As of midnight of THIS report period	144	144			137	137			144	144		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,138	4,138			3,082	3,082			1,056	1,056		
B. Medicaid (Conn.)	38,248	38,248			28,057	28,057			10,191	10,191		
C. Medicaid (other states)												
D. Private Pay	3,340	3,340			2,571	2,571			769	769		
E. State SSI for RCH												
F. Other (Specify) Mgd Care, Commercial, Hospic	3,808	3,808			2,818	2,818			990	990		
G. Total Care Days During Period (3A thru F)	49,534	49,534			36,528	36,528			13,006	13,006		
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)**	49,534	49,534			36,528	36,528			13,006	13,006		

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Schedule of Resident Statistics (Cont'd)

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

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	14	110		20				
Per Diem Rate								
a. One bed rm.	Various	247.97		480.00				
b. Two bed rms.	Various	247.97		460.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	4,601	4,601		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,320	1,320		
2. Restorative Treatments				
C. Other	11,890	11,890		
D. ***Total Physical Therapy Treatments***	17,811	17,811		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	854	854		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	301	301		
2. Restorative Treatments				
C. Other	1,727	1,727		
D. ***Total Speech Therapy Treatments***	2,882	2,882		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	4,748	4,748		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,638	1,638		
2. Restorative Treatments				
C. Other	13,998	13,998		
D. ***Total Occupational Therapy Treatments***	20,384	20,384		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Brookview Corporation d/b/a West Hartford Health & Rehab	1057-C	9/30/2016	10	37

Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	144,092	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	310,792	12,531				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	504,647	26,849				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	69,508	2,122				
b. Other Maintenance Workers	61,711	2,121				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
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	204,294	4,265				
b. RN						
1. Direct Care	792,027	22,903				
2. Administrative**	473,729	14,150				
c. LPN						
1. Direct Care	1,478,208	44,114				
2. Administrative**						
d. Aides and Attendants	2,308,005	130,123				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	174,300	7,558				
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	204,490	7,104				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	6,725,803	275,920				

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.
** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.
*** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

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

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

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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Leonard Schwartz					President			Avon Convalescent Home, 652 West Avon Rd, Avon, CT	See C/R	
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Brookview Corporation d/b/a West Hartford Health & Rehabilitation C	1057-C	9/30/2016	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* **										
Theresa Sanderson	144,092			Non Discrim	Administrator	2,080	A2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian	80,380	1,203				
2. Dentist	7,632	156				
3. Pharmacist	10,566	163				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	323,032	4,081				
b. Other	5,441	Supplies				
6. Social Worker	699	24				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	63,000	880				
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)						
Psychiatrist, Resp. Therapist, & Nursing	48,261	126				
9. Speech Therapist						
a. Resident Care	99,245	2,578				
b. Other						
10. Occupational Therapist						
a. Resident Care	344,180	5,723				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	44,965	424				
2. Administrative***						
b. LPN						
1. Direct Care	12,313	235				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	1,039,714	15,593				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Brookview Corporation d/b/a West Hartford Health & R	1057-C	9/30/2016	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Healthcare Services, 3220 Tillman Drive, Bensalem, PA 19020	Dietician	○	⊙	N/A
Geri Dent, PO Box 290539, Wethersfield, CT, 06129-0539	Dentist - Monthly visits	○	⊙	N/A
Omnicare Pharmacy, 525 Knotter Drive, Cheshire, CT 06410	Pharmacist - Audits, quality assurance	○	⊙	N/A
Value Rx, 54 Tuttle Place, Middletown, CT 06457	Pharmacist - Audits, quality assurance	○	⊙	N/A
Alliance Rehab of CT, 1520 Kensington Road, Suite 105, Oak Brook, IL 60523	PT, OT and ST	○	⊙	N/A
Gregory Walsh, 20 Isham Road, West Hartford, CT, 06107	Medical Director	○	⊙	N/A
Raymond Chagnon, 490 Blue Hills Ave, Hartford, CT 06112	Sub-Acute Medical Director	○	⊙	N/A
Keating, 6 Northwestern Dr #201, Bloomfield, CT 06002	Associate Medical Director	○	⊙	N/A
ProCaire, PO Box 801, Tolland, CT 06084	Respiratory Therapist - bedside evaluations	○	⊙	N/A
Celtic Consulting, 507 East Main Street, Suite 308, Torrington, CT 06790	Nursing Department Consultant	○	⊙	N/A
The Nurse Network, 635 Main Street, Plantsville, CT 06479	LPN's & RN's	○	⊙	N/A
SDX Swallowing, 21 Waterville Road, Avon, CT 06001	Bedside Swallowing Eval	○	⊙	N/A
Joy Pizzuto	Social Worker	○	⊙	N/A
Heather Carolan	Social Worker	○	⊙	N/A
J. Morrissey, 289 Broad St, Windsor, CT 06095	Nursing Recruitment Specialist	○	⊙	N/A
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Brookview Corporation d/b/a West Hartford Hea	1057-C	9/30/2016	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	187,872	187,872		
2. Disability Insurance	$				
3. Unemployment Insurance	$	110,904	110,904		
4. Social Security (F.I.C.A.)	$	499,466	499,466		
5. Health Insurance	$	899,683	899,683		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	270,881	270,881		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	30,812	30,812		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	333,466	333,466		
d. Accounting and Auditing	$	47,290	47,290		
e. Legal (*Services should be fully described on Page 7)*	$	49,616	49,616		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	25,921	25,921		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	10,954	10,954		
2. Cellular Phones	$	1,593	1,593		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$	250	250		
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	886,014	886,014		
Subtotal	$	3,354,722	3,354,722		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
	-		
Union Training	$ 26,512		
Union Dues	$ (64)		
New Hire Expense	$ 2,972		
Employee Physicals/Medication	$ 1,392		
Total	$ 30,812	$ -	$ -

Schedule of Other Taxes

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

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Brookview Corporation d/b/a West Hartford Health &	1057-C	9/30/2016	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		3,354,722	3,354,722		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$	11,007	11,007		
4. Employee Travel	$	3,537	3,537		
5. Education Expenses Related to Seminars and Conventions	$	18,566	18,566		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	6,019	6,019		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	39,027	39,027		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	6,340	6,340		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	11,306	11,306		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions***	$	1,150	1,150		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	270,846	270,846		
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	48,181	48,181		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	3,770,701	3,770,701		

* 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)
	-		
Business Promotion	$ 39,027		
Total Other Advertising	$ 39,027	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
	-		
American College of Health Care Administrators	$ 310		
Association of Long Term Care Financial Managers	$ 80		
Infection Control Nurse of Connecticut	$ 80		
CT Association of Health Care Facilities	$ 10,836		
Total Dues	$ 11,306	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
	-		
Donation Expense	$ 1,150		
Total Contributions	$ 1,150	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
	-		
Licenses	$ 2,801		
Late Fees & Fines	$ 36,114		
Bank Charges	$ 7,641		
Penalties	$ 1,625		
Total Other Administrative and General	$ 48,181	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
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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 #
N/A			

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

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CSP-18 Rev. 9/2002

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
Brookview Corporation d/b/a West Hartford Health &	1057-C	9/30/2016	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	417,167	417,167		
2. Non-Food Supplies	$	18,033	18,033		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	58,231	58,231		
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	493,431	493,431		

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

H.	Is cost of employee meals included in 2E?	⊙ Yes	○ No		
I.	Did you receive revenue from employees?	⊙ Yes	○ No	If yes, specify amt.	$295
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				Pg. 18 / Line 2a1
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	○ Yes	⊙ No	If yes, specify cost.	
L.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.	
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.	
O.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.	
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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CSP-19 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page of
Brookview Corporation d/b/a West Hartford Health & R	1057-C	9/30/2016	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $	7,596	7,596		
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. $				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	340,065	340,065		
c. Management Services**	$				
d. Other (*Specify*) Laundry Supplies	$	9,691	9,691		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	357,352	357,352		

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

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Brookview Corporation d/b/a West Hartford He	1057-C	9/30/2016	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	33,235	33,235		
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$	540,586	540,586		
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	573,821	573,821		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Omnicare Pharmacy		$	377,520	377,520		
b. Medicine Cabinet Drugs		$	217,054	217,054		
c. Medical and Therapeutic Supplies		$	44,951	44,951		
d. Ambulance/Limousine***		$	13,944	13,944		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	8,768	8,768		
f. X-rays and Related Radiological Procedures***		$	20,694	20,694		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	31,507	31,507		
i. Recreation		$	18,878	18,878		
j. Other (Specify)**** See Attached Schedule		$	147,089	147,089		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	880,405	880,405		

* 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)
	-		
Outside Medical Appointments	$ 11,923		
Therapy Equipment Rental	$ 17,220		
IV Therapy Expense	$ 9,059		
Supplies Patient Personal	$ 4,543		
Nursing Equipment Rental	$ 63,329		
Nursing Equipment Med A	$ 7,452		
Medical Software Subscriptions	$ 33,563		
Total Other Resident Care	$ 147,089	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Brookview Corporation d/b/a West Hartford Health & Rehabilitation Center	1057-C	9/30/2016	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Aegis Energy Service	PO Box 2511, Springfield, MA 01101	○	⊙	N/A	Co-generation maintenance	12,150			22	6f
Saucier Mechanical S	148 Norton St, Plantsville, CT 06479	○	⊙	N/A	HVAC	6,624			22	6a&f
Avon Health Center	652 W Avon Road, Avon, CT 06001	⊙	○	Director of Operations - Russell Schwartz	Administrative Support	185,027			16	m11
TM Technology	60 High Hill Road, Wallingford, CT 06492	○	⊙	N/A	IT installation, maintenance and support	39,271			16	m11
SigmaCare/Ehealth	floor, New York, NY 10018	○	⊙	N/A	system maintenance and support	30,346			20	5j
Healthcare Services	3220 Tillman Drive, Bensalem, PA 19020	○	⊙	N/A	Housekeeping, Laundry and Dietary Services	1,436,080			Var	Var
Paylocity	Arlington Heights, IL 60004	○	⊙	N/A	Payroll Processing	21,307			16	m11
Collaborative Lab Service	114 Woodland St, Hartford, CT	○	⊙	N/A	Laboratory Services	30,713			20	5h
NOA Diagnostics	6851 Jericho Tpke/Suite 150, Syosset, NY 11791	○	⊙	N/A	X-ray Services	17,942			20	5f
Paine's Recycling	P.O. Box 307, Simsbury, CT	○	⊙	N/A	Rubbish Removal	19,561			22	6f
Peter's Landscaping	806 Hillstown Rd, Manchester, CT 06040	○	⊙	N/A	Groundskeeping	12,086			22	6f
Goldstar Property Maintenance	471 New Britain Ave, Unionville, CT 06085	○	⊙	N/A	Snow Removal	11,167			22	6f
		○	⊙							
		○	○							

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Brookview Corporation d/b/a West Hartford H	1057-C	9/30/2016	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	43,264	43,264		
b. Heat	$	63,176	63,176		
c. Light & Power	$	64,848	64,848		
d. Water	$	49,629	49,629		
e. Equipment Lease (*Provide detail on page 6*)	$	19,556	19,556		
f. Other (*itemize*)	$	93,782	93,782		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	334,255	334,255		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	16,641	16,641		
d. Movable Equipment	$	125,283	125,283		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	141,924	141,924		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	177,734	177,734		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	177,734	177,734		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	500,864	500,864		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	115,526	115,526		
c. Personal property taxes	$	23,864	23,864		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	959,912	959,912		

* 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)
	-		
Groundskeeping	$ 13,213		
Rubbish Removal	$ 24,514		
Snow Removal	$ 11,167		
Purchased Maintenance Contract	$ 44,888		
Total Other Repairs and Maintenance	$ 93,782	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Brookview Corporation d/b/a West Hartford Health & Rehabilitation C	1057-C	9/30/2016	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	214,846		214,846	106,426	S/L	Various	15,907	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	3,670		3,670		S/L	Various	734	
C-4. Subtotal								16,641

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			Var	Var	2,088,365		2,088,365	1,474,135	S/L	Various	117,706	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			Var	Var	40,200		40,200		S/L	Various	7,577	
D-3. Subtotal												125,283
E. ***Total Depreciation***												141,924

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Schedule of Land Improvements Acquired during this report period

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

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

Schedule of Building Improvements Acquired during this report period

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

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

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Various	See attached (Related Party)	$ 3,670	Various	$ 734	
Total additions for Non-Movable Equipment		$ 3,670		$ 734	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Various	See attached	$ 33,554	Various	$ 6,912	
Various	See attached (Related Party)	$ 6,646	Various	$ 665	
Total additions for Movable Equipment		$ 40,200		$ 7,577	*
Deletions:					
Total deletions for Movable Equipment		$ -		$ -	**

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Various	See attached	$ 9,789	Various	$ 489	
Various	See attached (Related Party)	$ 102,711	Various	$ 7,240	
Total additions for Leasehold Improvement		$ 112,500		$ 7,729	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Brookview Corporation d/b/a West Hartford Health & Rehab	1057-C	9/30/2016	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	Var	Var	Various	3,614,811	2,224,204	S/L	Var	170,005	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	Var	Var	Various	112,500		S/L	Var	7,729	
C-4. Subtotal									177,734
D. ***Total Amortization***									177,734

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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CSP-25 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Brookview Corporation d/b/a West Ha	1057-C	9/30/2016	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	160
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)	Fixed			
b. Date Mortgage Obtained	08/26/13			
c. Interest Rate for the Cost Year	4.05%			
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	6,811,600			
f. Principal balance outstanding as of 9/30/2016	6,459,937			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Brookview Corporation d/b/a West H	1057-C	9/30/2016	26 | 37

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

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Brookview Corporation d/b/a West	1057-C	9/30/2016	27 | 37

Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment			$				
A. Item	Rate	Amount					
Lender							
Address of Lender							
2. Other (*Specify*)			$				
A. Item	Rate	Amount					
Lender							
Address of Lender							
B. Item	Rate	Amount					
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)			$				
12. D. Other Interest Expense (*Specify*)			$				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)			$				
14. Insurance							
a. Insurance on Property (buildings only)			$	107,289	107,289		
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)***			$	107,289	107,289		
15. ***Total All Expenditures (A-13 thru C-14)***			$	15,242,683	15,242,683		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Brookview Corporation d/b/a West Hartford Health & Rehabili	1057-C	9/30/2016	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	B10a	Occupational Therapy $	344,180	344,180		
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	333,466	333,466		
10.	15	1e	Accounting & Legal $	7,478	7,478		
11.			Telephone $				
12.	15	1h2	Cellular Telephone $	153	153		
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.	16	L3	Gifts, flowers and coffee shops $	10,022	10,022		
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	m3	Unallowable Advertising * $	39,027	39,027		
19.			Income Tax / Corporate Business Tax $				
20.	16	m10	Fund Raising / Contributions $	1,150	1,150		
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	37,739	37,739		
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) $	773,215	773,215		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Salaries Adjustment			$ -	$ -	$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Late Fees & Fines	$ 36,114		
16	m13	Penalties	$ 1,625		
Total Other A&G Adjustments			$ 37,739	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Brookview Corporation d/b/a West Hartford Health & Rehab	1057-C	9/30/2016	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	773,215	773,215		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs $	377,520	377,520		
28.	20	5d	Ambulance/Limousine $	13,944	13,944		
29.	20	5f	X-rays, etc $	20,694	20,694		
30.	20	5h	Laboratory $	31,507	31,507		
31.	20	5c	Medical Supplies $	10,747	10,747		
32.	20	5e2	Oxygen (non emergency) $	8,768	8,768		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	11,995	11,995		
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.			Radio and Television Revenue $				
44.			Vending Machine Revenue $				
45.			Purchase Discounts and Allowances $				
46.			Duplications of functions or services $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest $				
48.			Interest Income on Accounts Rec $				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule $				
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
51.			***Total Amount of Decrease (Items 1 - 50)*** $	1,248,390	1,248,390		

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

Attachment Page 29

Brookview Corporation d/b/a West Hartford Health & Rehabilitation Center
9/30/2016

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Supplies Patient Personal	$ 4,543		
20	5j	Nursing Equipment Med A	$ 7,452		
Total Other Ancillary Costs			$ 11,995	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

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

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Brookview Corporation d/b/a West Hartfc	1057-C	9/30/2016	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	16,331,642	16,331,642		
b. Medicaid Room and Board Contractual Allowance **	$	(6,938,994)	(6,938,994)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,803,135	1,803,135		
b. Medicare Room and Board Contractual Allowance **	$	306,030	306,030		
4. a. Private-Pay Residents and Other	$	3,078,637	3,078,637		
b. Private-Pay Room and Board Contractual Allowance **	$	(141,130)	(141,130)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	225,751	225,751		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(224,795)	(224,795)		
c. Prescription Drugs - Non-Medicare	$	160,694	160,694		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(160,694)	(160,694)		
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	$	347,717	347,717		
b. Physical Therapy - Medicare Contractual Allowance **	$	(167,803)	(167,803)		
c. Physical Therapy - Non-Medicare	$	176,386	176,386		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(173,491)	(173,491)		
4. a. Speech Therapy - Medicare	$	188,216	188,216		
b. Speech Therapy - Medicare Contractual Allowance **	$	(111,073)	(111,073)		
c. Speech Therapy - Non-Medicare	$	98,893	98,893		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(98,806)	(98,806)		
5. a. Occupational Therapy - Medicare	$	342,983	342,983		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(232,907)	(232,907)		
c. Occupational Therapy - Non-Medicare	$	198,060	198,060		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(119,976)	(119,976)		
6. a. Other *(Specify)* - Medicare	$	7,296	7,296		
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	14,895,771	14,895,771		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	2	2		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	809	809		
V. Total Other Revenue (1 thru 8)	$	811	811		
VI. Total All Revenue (III +V)	$	14,896,582	14,896,582		

* *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)
		-		
30 II 6a	Lab Medicare A	$ 20,804		
30 II 6a	Allow Lab MCR A	$ (20,804)		
30 II 6a	X-ray Medicare A	$ 10,673		
30 II 6a	Allow X-ray MCR A	$ (10,673)		
30 II 6a	Allow Pharmacy MCR B	$ (69)		
30 II 6a	Lab Insurance B	$ 7,777		
30 II 6a	Part B Ancillary Income	$ (412)		
Total Other Resident Revenue - Medicare		$ 7,296	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
		-		
30 II 6b	Lab Insurance Other	$ 17,085		
30 II 6b	Allow Lab Insurance Other	$ (17,085)		
30 II 6b	X-ray Insurance Other	$ 8,764		
30 II 6b	Allow X-ray Insurance Other	$ (8,764)		
Total Other Resident Revenue		$ -	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
			-		
30 IV 5	Medicare Interest Income	N/A	$ 2		
Total Interest Income			$ 2	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
		-		
30 IV 8	Prior Period Revenue	$ 809		
Total Other Revenue		$ 809	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Brookview Corporation d/b/a West Har	1057-C	9/30/2016	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 230,996
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 4,592,383
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 79,578
5. Prepaid Expenses				$ 19,004
a. Prepaid Insurance		5,048		
b. Prepaid Real/Property Taxes		3,684		
c. Prepaid Other		10,272		
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 4,921,961
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	3,727,311		$ 1,325,373
	Accum. Depreciation	2,401,938	Net	
5. Non-Movable Equipment	*Historical Cost	218,516		$ 95,449
	Accum. Depreciation	123,067	Net	
6. Movable Equipment	*Historical Cost	2,128,565		$ 529,147
	Accum. Depreciation	1,599,418	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ (42,661)
F/S vs C/R NBV		(42,661)		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 1,907,308

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Brookview Corporation d/b/a West Har	1057-C	9/30/2016	32	37

Account				Amount
			Total Brought Forward:	$ 6,829,269
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 6,829,269

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Brookview Corporation d/b/a West Hartford H	1057-C	9/30/2016	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 961,718
2. Notes Payable (*itemize*)					$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)					$ 416,689
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 8,644
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$ 1,524,729
Credit Balance Liabilities	776,199	Accrued Accounting	16,006		
Due to Cash Resident Funds	84,417	Accrued User Fee	234,478		
Due to Avon Convalescent Home	254,986	Accrued Interest	65		
Accrued Pension	56,360	Due to Medicaid	102,218		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 2,911,780

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Brookview Corporation d/b/a West Hartfor	1057-C	9/30/2016	34	37

Account	Amount
Total Brought Forward:	2,911,780
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

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

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 2,911,780

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

Name of Facility	License No.	Report for Year Ended	Page	of
Brookview Corporation d/b/a West Ha	1057-C	9/30/2016	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$ 1,076,796
	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	$ 1,076,796
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$ 391,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 2,616,217
	6. Gain or Loss for Period 10/1/2015 thru 9/30/2016	$ (166,524)
	7. Total Net Worth	$ 2,840,693
C.	***Total Reserves and Net Worth***	$ 3,917,489
D.	***Total Liabilities, Reserves, and Net Worth***	$ 6,829,269

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Brookview Corporation d/b/a West Hartf	1057-C	9/30/2016	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2015			$ 3,271,328
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 14,896,582
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 15,063,106
D.	Net Income or Deficit			$ (166,524)
E.	Balance			$ 3,104,804
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Total Expenses Per Page 27 $15,242,683			
	(Less) F/S vs C/R Depreciation (179,577)			
	Total F/S Expenses $15,063,106			
	2. Other (*itemize*)			
	Prior Period Adjustment			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$ 264,111
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	Leonard Schwartz	Owner	264,111	
	2. Other Withdrawings *(Specify)*			$
	Purpose	Amount		
	3. Total Deductions			$ 264,111
H.	***Balance at End of Period*** 09/30/16			$ 2,840,693

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Brookview Corporation d/b/a West	1057-C	9/30/2016	37	37

Check appropriate category

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

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed

Printed Name of Preparer	
Matthew S. Bavolack	
Addres Address	Phone Number
555 Long Wharf Drive, New Haven, CT 06511	203-781-9600

Subject to the attached accountants' consulting report