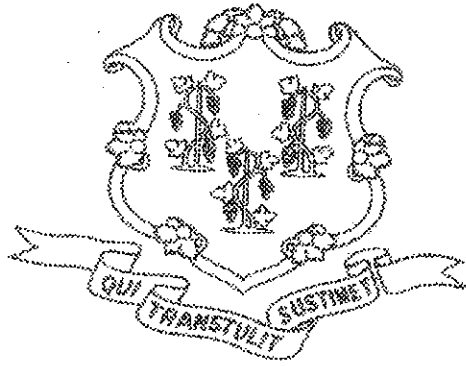


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2019

Name of Facility (as licensed) Westside Care Center, LLC	
Address (No. & Street, City, State, Zip Code) 349 Bidwell Street, Manchester, CT 06040	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019

License Numbers:	CCNH 2291	RHNS	(Specify)	Medicare Provider 07-5252
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Medicaid Provider Numbers:	CCNH 78707	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

General Information

Name of Facility (as licensed) Westside Care Center, LLC	License No. 2291	Report for Year Ended 9/30/2019	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 Westside Care Center, LLC [facility name], for the cost report period beginning October 1, 2018 and ending September 30, 2019, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) Sylvia Szleszynski			Printed Name (Owner) Chris Wright		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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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 Westside Care Center, LLC		Period Covered:	From 10/1/2018	To 9/30/2019
Address of Facility 349 Bidwell Street, Manchester, CT 06040				
Report Prepared By iCare Management, LLC		Phone Number 860-570-2140	Date 2/15/2020	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-647-9191		Report for Year Ended 9/30/2019	Page 2	of 37
Name of Facility (as shown on license) Westside Care Center, LLC		Address (No. & Street, City, State, Zip) 349 Bidwell Street, Manchester, CT 06040		
License Numbers:	CCNH 2291	RHNS (Specify)	Medicare Provider No. 07-5252	
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 checked="" type="radio"/> LLC <input type="radio"/> Partnership <input 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 Sylvia Szleszynski		Nursing Home Administrator's License No.:	2096	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

2291

Related Parties*

Name of Facility		License No.	Report for Year Ended		Page	of	
Westside Care Center, LLC		2291	9/3/2019		4	37	
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 %**				
Bidwell Care Center, LLC	333 Bidwell St. Manchester, CT 06040			Shared Employees		17,052	(17,052)
Chelsea Place Care Center, LLC	25 Lorraine St. Hartford, CT 06105			Shared Employees		(763)	763
Chestnut Point Care Center, LLC	171 Main St. East Windsor, CT 06088			Shared Employees		(7,536)	7,536
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032			Shared Employees		-	-
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088			Shared Employees		-	-
Meriden Care Center, LLC (Silver Springs)	33 Roy St. Meriden, CT 06450			Shared Employees		3,063	(3,063)
Trinity Hill Care Center, LLC	151 Hillside Ave. Hartford, CT 06106			Shared Employees		1,658	(1,658)
Westside Care Center, LLC	349 Bidwell St. Manchester, CT 06040			Shared Employees		-	-
Wintonbury Care Center, LLC	140 Park Ave. Bloomfield, CT 06002			Shared Employees		(323)	323
Secure Care Center LLC	60 West Street, Rocky Hill, CT 06067			Shared Employees		10,440	(10,440)
Universal Healthcare Holdings, LLC	5 Greenwood Street, Hartford, CT 06106			Shared Employees		-	-
Touchpoints at Homecare LLC	1838 Silas Deane Hwy, Rocky Hill, CT 06067			Shared Employees		-	-
Elevate Counseling Services LLC	341 Bidwell St. Manchester, CT 06040			Shared Employees		-	-
Touchpoints Therapy LLC	341 Bidwell St. Manchester, CT 06040			OT/PT/ST	13 5,8,10	426,737	(426,737)
Realty	N/A			Building Lease & Rent	22,22,27,10,9,14	-	-
iCare Management, LLC	341 Bidwell St. Manchester, CT 06040			iCare Helt-Legal, Postage, Emp Recruitment & Marketing	16, 15 M.E	17,596	(17,596)
iCare Health Management, LLC	341 Bidwell St. Manchester, CT 06040			Shared EEs not part of mgmt agmt		187,939	(187,939)
				Management Services, Direct	20 5]	215,914	(215,914)
				Management Services, Indirect	20 5]	30,223	(30,223)
				Management Services, Administrative	16 M12	382,374	(382,374)
All Care Centers, mgmt co, realty cos				Share Common 401k, Pension and Insurance plans, courier, legal and various other services			

* Use additional sheets if necessary.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Westside Care Center, LLC	License No. 2291	Report for Year Ended 9/30/2019	Page 5	of 37
If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:				
Item	Method of Allocation			
Dietary	Number of meals served to residents			
Laundry	Number of pounds processed			
Housekeeping	Number of square feet serviced			
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants			
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist <i>(See listing page 13)</i>			
Maintenance and operation of plant	Square feet			
Property costs (depreciation)	Square feet			
Employee health and welfare	Gross salaries			
Management services	Appropriate cost center involved			
All other General Administrative expenses	Total of Direct and Allocated Costs			
The preparer of this report must answer the following questions applicable to the cost information provided.				
1. In the preparation of this Report, were all costs allocated as required? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.				
2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.				
3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)				
<input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.				

General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility Westside Care Center, LLC		License No. 2291	Report for Year Ended 9/30/2019	Page 6	of 37	
Name and Address of Lessor	Related * to Owners, Operators, Officers		Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No				
Accelerated Care Plus Corp. 4850 Joule Street, Suite A-1 Reno, ADP, Inc., One ADP Drive MS-100, Augusta, GA. 30909	<input type="radio"/>	<input checked="" type="radio"/>	05/18/10	1 yr with automatic	7,051	7,051
Wells Fargo C/O GE Capital C/O Ricoh USA, P.O.Box 41564, Philadelphia, PA. 19101	<input type="radio"/>	<input checked="" type="radio"/>	06/01/10	60 months & automatic	14,408	14,408
Mail Finance/Neopost New England, 25881 Newtwork Place, Chicago, IL. 60673	<input type="radio"/>	<input checked="" type="radio"/>	11/20/14	48 months	8,240	8,240
	<input type="radio"/>	<input checked="" type="radio"/>		Monthly	797	797
	<input type="radio"/>	<input checked="" type="radio"/>				
	<input type="radio"/>	<input checked="" type="radio"/>				
	<input type="radio"/>	<input checked="" type="radio"/>				
	<input type="radio"/>	<input checked="" type="radio"/>				
	<input type="radio"/>	<input checked="" type="radio"/>				
	<input type="radio"/>	<input checked="" type="radio"/>				
	<input type="radio"/>	<input checked="" type="radio"/>				
					Total ***	30,496

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

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

** Attach copies of newly acquired leases.

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

General Information and Questionnaire Accounting Basis

Name of Facility Westside Care Center, LLC	License No. 2291	Report for Year Ended 9/30/2019	Page 7	of 37
The records of this facility for the period covered by this report were maintained on the following basis: <input checked="" type="radio"/> Accrual <input type="radio"/> Cash <input type="radio"/> Modified Cash				
Is the accounting basis for this period the same as for the previous period? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain.				
Independent Accounting Firm				
Name of Accounting Firm 1 O'Connor, Davies LLP 2 3 4		Address (No. & Street, City, State, Zip Code) 100 Great Meadow Road, Ste 401, Wethersfield, CT 06109		
Services Provided by This Firm (<i>describe fully</i>)				
1	Taxes, financial statements, accounting support	\$	9,001	
2		\$		
3		\$		
4		\$		
			Charge for Services Provided \$ 9,001	
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. <input checked="" type="radio"/> Yes <input type="radio"/> No 15D				
Legal Services Information				
Name of Legal Firm or Independent Attorney 1 iCare Health Management, LLC 2 Starble and Harris 3 Durant Nichols / Robinson & Cole, LLP 4 Various others (American Arbitration , Various Arbitration, Murtha Cullina, Jackson Lewis) 5 Starble and Harris, iCare Health Management LLC			Telephone Number 860-570-2140 860-678-7775 860-275-8200 860-678-7775 & 860-570-2140	
Address (<i>No. & Street, City, State, Zip Code</i>) 1 341 Bidwell Street, Manchester CT 2 32 Main Street, Avon, CT 3 280 Trumbull St, Hartford, CT 4 5 32 Main Street, Avon, CT & 341 Bidwell Street, Manchester CT				
Services Provided by This Firm (<i>describe fully</i>)				
1	Lease and contract issues, general legal advice, Labor Law	\$	13,853	
2	Lease and contract issues, general legal advice, union funds advice	\$		
3	Employment law, arbitrations, contract negotiations	\$	12,819	
4	Employment Arbitrations, healthcare law	\$	(311)	
5	Conservatorships & Collections	\$	965	
			Charge for Services Provided \$ 27,325	
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. <input checked="" type="radio"/> Yes <input type="radio"/> No 15E				

Schedule of Resident Statistics

Name of Facility Westside Care Center, LLC	License No. 2291		Report for Year Ended 9/30/2019						Page	of		
			Period 10/1 Thru 6/30			Period 7/1 Thru 9/30			8	37		
			Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Total	CCNH	RHNS	Total	CCNH	RHNS
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	162	162		162	162		162	162		162	162	
B. On last day of THIS report period	162	162		162	162		162	162		162	162	
2. Number of Residents												
A. As of midnight of PREVIOUS report period	156	156		156	156		151	151		151	151	
B. As of midnight of THIS report period	154	154		151	151		154	154		154	154	
3. Total Number of Days Care Provided During Period												
A. Medicare	1,388	1,388		1,178	1,178		210	210		210	210	
B. Medicaid (Conn.)	53,912	53,912		40,248	40,248		13,664	13,664		13,664	13,664	
C. Medicaid (other states)												
D. Private Pay	651	651		482	482		169	169		169	169	
E. State SSI for RCH												
F. Other (Specify) Insurance	141	141		141	141		14,043	14,043		14,043	14,043	
G. Total Care Days During Period (3A thru F)	56,092	56,092		42,049	42,049		14,043	14,043		14,043	14,043	
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												
Total Resident Days (3G + 4A + 4B)	56,092	56,092		42,049	42,049		14,043	14,043		14,043	14,043	

Schedule of Resident Statistics (Cont'd)

Name of Facility Westside Care Center, LLC	License No. 2291	Report for Year Ended 9/30/2019	Page 9	of 37
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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 (1)	RHNS (2)	(Specify) (3)	Lost			Gained			CCNH	RHNS	(Specify)	
				(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	3		149		2				
Per Diem Rate									
a. One bed rm.	450.00		253.00		472.00				
b. Two bed rms.									
c. Three or more bed rms.									

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	2,881	2,881		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,353	1,353		
2. Restorative Treatments	3,047	3,047		
C. Other	3,670	3,670		
D. Total Physical Therapy Treatments	10,951	10,951		

8. Total Number of Speech Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	199	199		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	91	91		
2. Restorative Treatments	187	187		
C. Other	206	206		
D. Total Speech Therapy Treatments	683	683		

9. Total Number of Occupational Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	2,996	2,996		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,143	1,143		
2. Restorative Treatments	3,040	3,040		
C. Other	3,462	3,462		
D. Total Occupational Therapy Treatments	10,641	10,641		

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Westside Care Center, LLC	2291	9/30/2019	10	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)	118,289	2,085				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	260,283	12,456				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	67,127	2,086				
c. Dietary Workers	519,030	29,313				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	59,372	2,014				
b. Other Maintenance Workers	42,702	2,786				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	-19					
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	231,667	4,031				
b. RN						
1. Direct Care	254,553	5,298				
2. Administrative**	279,811	6,295				
c. LPN						
1. Direct Care	1,569,627	51,306				
2. Administrative**						
d. Aides and Attendants	2,540,013	132,482				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	185,903	9,019				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	185,786	6,498				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	72,703	3,929				
<i>A-13. Total Salary Expenditures</i>	6,386,848	269,598				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
UNIT SECRETARIES SALARIES	\$ -	-			\$ -	-
MEDICAL RECORDS SALARIES	\$ 34,180	1,997			\$ -	-
CENTRAL SUPPLY SALARIES	\$ 38,524	1,932			\$ -	-
RESPIRATORY THERAPY SALARIES	\$ -	-			\$ -	-
Total	\$ 72,703	3,929	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
MEDICAL RECORDS CONTRACT SERVICE	\$ (14,939)	(789)			\$ -	-
ADMISSIONS C/S LABOR	\$ 54,127	1,134			\$ -	-
CENTRAL SUPPLY CONTRACT SERVICE	\$ 6,604	193			\$ -	-
ADMINISTRATIVE CONTRACT SERVICE LABOR	\$ 119,938	2,919			\$ -	-
RESPIRATORY THERAPY CONTRACT SERVICES	\$ 386	0			\$ -	-
PHYSICAL THERAPY C/S MEDICIAD	\$ 71,755	1,178			\$ -	-
SPEECH THERAPY C/S Medicaid	\$ 8,122	1,121			\$ -	-
OCCUPATIONAL THERAPY C/S MEDICIAD	\$ 68,833	135			\$ -	-
Total	\$ 314,827	5,891	\$ -	-	\$ -	-

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

Name of Facility Westside Care Center, LLC		License No. 2291		Report for Year Ended 9/30/2019		Page 11	of 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) Westside Care Center, LLC		License No. 2291	Report for Year Ended 9/30/2019		Page 12	of 37		
Name	Salary Paid		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***								
Sylvia Szleszynski	74,244		Administrator	1,445	A2			
Patrick Neagle	44,045		Administrator	640	A2			
Section IV - Assistant Administrators			Administrator		A2			

*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		
Westside Care Center, LLC	2291	9/30/2019	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist	30,203	302				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	70,657	681				
b. Other						
6. Social Worker	120,169	2,319				
7. Recreation Worker	20,307	35+Cable				35+Cable
8. Physicians						
a. Medical Director (entire facility)	51,838	430				
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) Physician Care Contract Services	12,041	62				
9. Speech Therapist						
a. Resident Care	9,946	59				
b. Other						
10. Occupational Therapist						
a. Resident Care	74,759	323				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	234,893	3,865				
2. Administrative***	5,182	104				
b. LPN						
1. Direct Care	7,082	168				
2. Administrative***						
c. Aides	(2,638)	(31)				
d. Other						
12. Other (Specify) See Attached Schedule	314,827	5,891				
B-13 Total Fees Paid in Lieu of Salaries	949,265	14,171				

* 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 Westside Care Center, LLC		License No. 2291		Report for Year Ended 9/30/2019		Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers				Explanation of Relationship	
		Yes	No				
Tocuhpoints Therapy	Therapy	<input checked="" type="radio"/>	<input type="radio"/>			Common Ownership	
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver	Shared Employees	<input checked="" type="radio"/>	<input type="radio"/>			Common Ownership	
Pharm Scripts	Pharmacy Contract	<input type="radio"/>	<input checked="" type="radio"/>				
Guardian Consulting Srv	Pharmacy Consulting	<input type="radio"/>	<input checked="" type="radio"/>				
Healthdrive Physician Services	Audiology, Dental and Podiatry	<input type="radio"/>	<input checked="" type="radio"/>				
Ready Nurse, Nurse Network	Nursing pool (RN, LPN, CNA)	<input type="radio"/>	<input checked="" type="radio"/>				
IPC Hospitalists	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				

* Use additional sheets if necessary.
 ** 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
Westside Care Center, LLC	2291	9/30/2019		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 325,680	325,680			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$				
4. Social Security (F.I.C.A.)	\$ 547,458	547,458			
5. Health Insurance	\$ 1,128,807	1,128,807			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 382,268	382,268			
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>) See Attached Schedule	\$ 47,227	47,227			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 95,008	95,008			
d. Accounting and Auditing	\$ 9,001	9,001			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 27,325	27,325			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 18,433	18,433			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 26,038	26,038			
2. Cellular Phones	\$ 189	189			
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 250	250			
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	\$ 1,179,054	1,179,054			
Subtotal	\$ 3,786,739	3,786,739			

* 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	\$ 47,227		\$ -
Total	\$ 47,227	\$ -	\$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
INTERNET EXPENSES	\$ -		\$ -
Total	\$ -	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended		Page	of
Westside Care Center, LLC	2291	9/30/2019		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:	3,786,739	3,786,739			
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 260	260			
3. Gifts to Staff and Residents	\$ 803	803			
4. Employee Travel	\$ 1,493	1,493			
5. Education Expenses Related to Seminars and Conventions	\$ 4,699	4,699			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$ 262	262			
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 9,935	9,935			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 20,904	20,904			
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	\$ 3,987	3,987			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 10,968	10,968			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 694	694			
10. Contributions*** See Attached Schedule	\$ 360	360			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 118,857	118,857			
12. Administrative Management Services**	\$ 382,374	382,374			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 44,086	44,086			
C-14 Total Administrative & General Expenditures	\$ 4,386,420	4,386,420			

* 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)
MEALS	\$ 262		\$ -
Total Other Travel and Entertainment	\$ 262	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
COMMUNICATIONS SPECIAL EVENTS	\$ 20,904		\$ -
Total Other Advertising	\$ 20,904	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
ALTCFM			
CAHCF Dues	\$ 10,808		\$ -
OTHER DUES	\$ 160		\$ -
Total Dues	\$ 10,968	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
CONTRIBUTIONS	\$ 360		\$ -
Total Contributions	\$ 360	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
SOCIAL SERVICE SUPPLIES	\$ -		\$ -
SOC.SVC MINOR EQUIPMENT	\$ -		\$ -
ADMINISTRATIVE MINOR EQUIPMENT	\$ 1,369		\$ -
EMPLOYEE RELATIONS	\$ 5,419		\$ -
EMPLOYEE RELATIONS-OTHER	\$ 1,411		\$ -
PERMITS & LICENSES	\$ 2,951		\$ -
VOLUNTEER EXPENSE	\$ -		\$ -
BANK FEES	\$ 7,311		\$ -
CMS REVISIT USER FEES	\$ -		\$ -
PENALTIES	\$ 13,689		\$ -
LATE FEES	\$ 755		\$ -
INTERNET EXPENSES	\$ 11,182		\$ -
Rounding	\$ (1)		
Total Other Administrative and General	\$ 44,086	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Westside Care Center, LLC	2291	9/30/2019	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 #
iCare Management, LLC/iCare Health Management, LLC	382,374	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	215,914	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	30,223	MANAGEMENT FEES- INDIRECT CARE	Pg 20 j

* 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
Westside Care Center, LLC		2291	9/30/2019		18	37
Item		Total	CCNH	RHNS	(Specify)	
2. Dietary						
a. In-House Preparation & Service						
1.	Raw Food	\$ 342,781	342,781			
2.	Non-Food Supplies	\$ 35,421	35,421			
3.	Other (Specify) _____ DIETARY SUPPLEMENTS	\$ 22,767	22,767			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$ 40,088	40,088			
c. Other (Specify) _____ DIETARY MINOR EQUIPMENT		\$ 12,297	12,297			
2D. Total Dietary Expenditures (2a + b + c + d)		\$ 453,354	453,354			
2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)	
F.	Resident Meals: Total no. of meals served per day:*	461	461			
G.	Is cost of employee meals included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No				
H.	Did you receive revenue from employees?	<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify amt.		
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)					
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.		
K.	Is any revenue collected 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)					
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.		
N.	Is any revenue collected from employees?	<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify amt.		
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)					

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

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

Name of Facility		License No.	Report for Year Ended	Page	of
Westside Care Center, LLC		2291	9/30/2019	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. \$	506	506	
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)		\$	440,242	440,242	
c. Other (Specify) LAUNDRY MINOR EQUIPMENT		\$	1,210	1,210	
3D. Total Laundry Expenditures (3a + b + c)		\$	441,958	441,958	
3E. Laundry Questionnaire					
F.	Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
G.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
H.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
I.	Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
J.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
K.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3D.

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Westside Care Center, LLC		2291	9/30/2019		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
1.	Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	32,937	32,937		
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. \$	468,501	468,501		
C.	Other (<i>Specify</i>)		\$			
	HOUSEKEEPING MINOR EQUIPMENT					
4D.	Total Housekeeping Expenditures (4a + b + c)		\$ 501,438	501,438		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from PHARMACY	\$	135,137	135,137		
b.	Medicine Cabinet Drugs	\$	8,359	8,359		
c.	Medical and Therapeutic Supplies	\$	122,324	122,324		
d.	Ambulance/Limousine***	\$	5,179	5,179		
e.	Oxygen					
1.	For Emergency Use	\$	1,829	1,829		
2.	Other***	\$				
f.	X-rays and Related Radiological Procedures***	\$	3,290	3,290		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	6,442	6,442		
i.	Recreation	\$				
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	326,574	326,574		
5M.	Total Resident Care Expenditures (5a - 5j)	\$	609,133	609,133		

* 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)
NURSING ADMIN SUPPLIES	\$ 93		\$ -
NURSING MINOR EQUIP	\$ 11,938		\$ -
MEDICAL RECORDS SUPPLIES	\$ (99)		\$ -
MEDICAL RECORDS MINOR EQUIPMENT	\$ 23		\$ -
MANAGEMENT ALLOCATIONS - DIRECT	\$ 215,914		\$ -
NON-COVERED PPS DR. VISITS	\$ (127)		\$ -
RESIDENT CARE SUPPLIES	\$ 43		\$ -
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 14,424		\$ -
PERSONAL CARE SUPPLIES	\$ 103		\$ -
INCONTINENCY SUPPLIES	\$ 563		\$ -
VACCINE RESIDENTS	\$ 55		\$ -
PATIENT SPECIAL NEEDS	\$ 1,009		\$ -
PHYSICAL THERAPY SUPPLIES	\$ -		\$ -
PHYSICAL THERAPY EQUIPMENT RENT	\$ -		\$ -
PHYSICAL THERAPY MINOR EQUIPMENT	\$ -		\$ -
OCCUPATIONAL THERAPY SUPPLIES	\$ -		\$ -
OCCUPATIONAL THERAPY EQUIP RENTAL	\$ -		\$ -
OCCUPATIONAL THERAPY MINOR EQUIP	\$ -		\$ -
SPEECH THERAPY SUPPLIES	\$ -		\$ -
SPEECH THERAPY EQUIPMENT RENT	\$ -		\$ -
SPEECH THERAPY MINOR EQUIPMENT	\$ -		\$ -
RENTALS FOR NURSING EQUIPMENT NON BILLABLE	\$ 18,328		\$ -
EQUIPMENT RENTAL: AIDS UNIT	\$ -		\$ -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ -		\$ -
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ (54)		\$ -
HI LOW BED RENTAL & MATTRESSES	\$ -		\$ -
IV THERAPY SUPPLIES	\$ 22,363		\$ -
IV THERAPY CONTRACT SERVICE	\$ -		\$ -
MEDICAL WASTE CONTRACT SERVICE	\$ 1,169		\$ -
ACTIVITIES SUPPLIES	\$ 8,494		\$ -
ACTIVITIES MINOR EQUIPMENT	\$ -		\$ -
MANAGEMENT ALLOCATION - INDIRECT	\$ 30,223		\$ -
ADMISSIONS SUPPLIES	\$ -		\$ -
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$ -		\$ -
STRIKE COSTS NON REIMBURSABLE	\$ 2,112		\$ -
Total Other Resident Care	\$ 326,574	\$ -	\$ -

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

Name of Facility Westside Care Center, LLC		License No. 2291	Report for Year Ended 9/30/2019	Page of 21 37						
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Housekeeping Services	468,501			20	4b
Health Services Group/Unitex	3220 Tillman Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Laundry Services	440,242			19	3b
Textile Rental Services		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Elevator Contract	6,126			22	6F
Eagle Elevator		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Medical Waste Snow	1,169			22	6F
Bioserve, Inc.		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Removal/Landscaping	15,645			22	6F
Brightview Landscapes/Primary Landscaping		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Trash removal	34,090			22	6F
CWPM		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Software Maintenance Contract	12,622			16	M11
American Health Tech		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Payroll Services	49,238			16	M11
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Resident Trust Software Computer Consulting Services	4,054			16	M11
National Datacare Corp		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Counter Services	3,408			16	M11
Prime Care Technology services		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Nursing Software	4,680			16	M11
Priority Express		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR					22	6F
Point Right Inc		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR						

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
Westside Care Center, LLC	2291	9/30/2019			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 59,102	59,102				
b. Heat	\$ 35,590	35,590				
c. Light & Power	\$ 150,193	150,193				
d. Water	\$ 58,885	58,885				
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$ 30,496	30,496				
f. Other <i>(itemize)</i>	\$ 102,060	102,060				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 436,327	436,327				
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$					
b. Building & Building Improvements	\$ 27,091	27,091				
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 41,163	41,163				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 68,254	68,254				
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 40,053	40,053				
d. Other <i>(Specify)</i>	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 40,053	40,053				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 284,356	284,356				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 126,184	126,184				
c. Personal property taxes	\$ 11,948	11,948				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 530,795	530,795				

* 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)
PLANT SUPPLIES	\$ 12,271		\$ -
PLANT CONTRACT SERVICE LABOR	\$ -		\$ -
ELEVATOR CONTRACT SERVICE	\$ 6,126		\$ -
FIRE/SPRINKLER CONTRACT SERVICE	\$ 8,847		\$ -
LANDSCAPING CONTRACT SERVICE	\$ 8,425		\$ -
SNOW REMOVAL CONTRACT SERVICE	\$ 6,885		\$ -
TRASH REMOVAL CONTRACT SERVICE	\$ 34,090		\$ -
HVAC CONTRACT SERVICE	\$ -		\$ -
SECURITY CONTRACT SERVICE	\$ -		\$ -
PLANT CONTRACT SERVICE OTHER	\$ 13,989		\$ -
PLANT MINOR EQUIPMENT	\$ 11,428		\$ -
RENT AUTO	\$ -		\$ -
RENT EQUIPMENT	\$ -		\$ -
RENT OTHER	\$ -		\$ -
Total Other Repairs and Maintenance	\$ 102,060	\$ -	\$ -

Depreciation Schedule

Name of Facility Westside Care Center, LLC		License No. 2291	Report for Year Ended 9/30/2019				Page 23	of 37	
Property Item		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. Land Improvements									
1. Acquired prior to this report period									
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		342,818		342,818	91,947			27,091	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
B-4. Subtotal									27,091
C. Non-Movable Equipment									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Movable Equipment									
1. Motor Vehicles (Specify name, model and year of each vehicle)									
a. Van Repair: Hillside Automotive Ceix									
b.									
c.									
d.									
2. Movable Equipment									
a. Acquired prior to this report period									
b. Disposals (attach schedule)									
c. Acquired during this report period (attach schedule)									
D-3. Subtotal		59,612		2,306	2,306			3,442	
E. Total Depreciation									41,163
									68,254

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:				
Total deletions for Non-Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Amortization Schedule*

Name of Facility Westside Care Center, LLC	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	of
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.				582,616	307,814			36,692	
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				62,460				3,362	
C-4. Subtotal									
D. Total Amortization									
									40,053
									40,053

* 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 Westside Care Center, LLC	License No. 2291	Report for Year Ended 9/30/2019	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*			If "Yes," complete Part B. If "No," complete Part C.		
<input type="radio"/> Yes			<input checked="" type="radio"/> No		
*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	04/01/1999				
2. Date Structure Completed					
3. If NOT Original Owner, Date of Purchase	04/01/99				
4. Date of Initial Licensure	04/01/99				
5. Total Licensed Bed Capacity	162				
6. Square Footage	80,850				
7. Acquisition Cost					
a. Land					
b. Building					
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)					
b. Date Mortgage Obtained					
c. Interest Rate for the Cost Year					
d. Term of Mortgage (number of years)					
e. Amount of Principal Borrowed					
f. Principal balance outstanding as of					
Complete if Mortgage was Refinanced During Current Cost Year					
g. Type of Financing (e.g., fixed, variable)					
h. Date of Refinancing					
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed					
l. Principal Outstanding on Note Paid-Off					
Part C - Arms-Length Leases for Real Property Improvements Only					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	
Summit Westside SNF, LLC	349 Bidwell Street, Manchester, CT	08/09/17	15 years with year extension	\$297,000 yr 1	

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Westside Care Center, LLC		2291	9/30/2019		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Westside Care Center, LLC		2291		9/30/2019		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$			
12. D. Other Interest Expense (Specify) INTEREST				\$ 60,486	60,486		
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$ 60,486	60,486		
14. Insurance							
a. Insurance on Property (buildings only)				\$ 9,724	9,724		
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$ 62,144	62,144		
2. Fire and Extended Coverage				\$			
3. Other (Specify) Other insurance, crime				\$ 6,423	6,423		
14d. Total Insurance Expenditures (14a + b + c)				\$ 78,291	78,291		
15. Total All Expenditures (A-13 thru C-14)				\$ 14,834,313	14,834,313		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Westside Care Center, LLC			2291	9/30/2019	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			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.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$ 95,008	95,008		
10.			Accounting	\$			
10a.			Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.			Unallowable Advertising *	\$ 20,904	20,904		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 45,175	45,175		
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)				\$ 161,087	161,087		

* 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.

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Westside Care Center, LLC			2291	9/30/2019	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 161,087	161,087		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$			
28.			Ambulance/Limousine	\$ 5,179	5,179		
29.			X-rays, etc	\$ 3,290	3,290		
30.			Laboratory	\$ 6,442	6,442		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ (127)	(127)		
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.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 175,870	175,870		

*** 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.

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5J		(127.33)		-
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)	-		
13	B9A	ST- Resident Care (for outpatient therapy - see schedule)	-		
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)	-		
Total Other Ancillary Costs			\$ (127)	\$ -	\$ -

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 - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	4A1	Houskeeping Supplies (for Outpatient Therapy - see schedule)	\$ -		
20	4B	Housekeeping purchased services (for Outpatient Therapy see schedule)	\$ -		
22	6B	Heat (for outpatient Therapy see schedule)	\$ -		
22	6C	Light and Power (for outpatient therapy see schedule)	\$ -		
22	6D	water (for outpatient therapy see schedule)	\$ -		
22	6A	Repair&Maint (for outpatient therapy see schedule)	\$ -		

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

Schedule of Other - Miscellaneous Administrative Adjustments

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

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

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Westside Care Center, LLC	2291	9/30/2019		30	37
Item	Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 13,397,661	13,397,661			
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>)	\$ 784,794	784,794			
b. Medicare Room and Board Contractual Allowance **	\$				
4. a. Private-Pay Residents and Other	\$ 366,696	366,696			
b. Private-Pay Room and Board Contractual Allowance **	\$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 67,389	67,389			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (67,389)	(67,389)			
c. Prescription Drugs - Non-Medicare	\$ 82,796	82,796			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (82,796)	(82,796)			
2. a. Medical Supplies - Medicare	\$ 56	56			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (56)	(56)			
c. Medical Supplies - Non-Medicare	\$ 2,707	2,707			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (2,707)	(2,707)			
3. a. Physical Therapy - Medicare	\$ 111,164	111,164			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (70,311)	(70,311)			
c. Physical Therapy - Non-Medicare	\$ 164,245	164,245			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (164,245)	(164,245)			
4. a. Speech Therapy - Medicare	\$ 15,219	15,219			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (9,184)	(9,184)			
c. Speech Therapy - Non-Medicare	\$ 25,082	25,082			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (25,082)	(25,082)			
5. a. Occupational Therapy - Medicare	\$ 128,882	128,882			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (84,322)	(84,322)			
c. Occupational Therapy - Non-Medicare	\$ 167,011	167,011			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (166,253)	(166,253)			
6. a. Other (<i>Specify</i>) - Medicare	\$				
b. Other (<i>Specify</i>) - Non-Medicare	\$ 248,351	248,351			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 14,889,708	14,889,708			
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 (<i>Specify</i>)	\$				
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ 46,862	46,862			
V. Total Other Revenue (1 thru 8)	\$ 46,862	46,862			
VI. Total All Revenue (III + V)	\$ 14,936,569	14,936,569			

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Lab Medicare	\$ 2,293		
	Lab Medicare CA	\$ (2,293)		
	Oxygen Medicare	\$ 5		
	Oxygen Medicare CA	\$ (5)		
	Equipment rental	\$ 519		
	Equipment rental CA	\$ (519)		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds Medicare	\$ -		
	Therapy Beds Medicare CA	\$ -		
	Radiology Medicare	\$ 1,245		
	Radiology Medicare CA	\$ (1,245)		
	IV Therapy	\$ 1,151		
	IV Therapy CA	\$ (1,151)		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose testing	\$ -		
	Glucose testing CA	\$ -		
	Outpatient therapy Medicare	\$ -		
	Total Other Resident Revenue - Medicare	\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Lab	3,851.10		
	Lab CA	(3,851.10)		
	Oxygen	\$ 80		\$ -
	Oxygen CA	\$ (80)		\$ -
	Equipment rental	\$ 11,530		
	Equipment rental CA	\$ (11,530)		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds	\$ -		
	Therapy Beds CA	\$ -		
	Radiology	\$ 1,890		
	Radiology CA	\$ (1,890)		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose Testing	\$ -		
	Glucose Testing CA	\$ -		
	IV therapy	\$ 29,689		\$ -
	IV therapy CA	\$ (29,689)		\$ -
	Flu shot revenue	\$ -		
	Outpatient therapy	\$ -		
	Outpatient therapy CA	\$ -		
	prior period revenue	\$ 99,729		
	Optum B	\$ 277,442		
	Optum B CA	\$ (123,667)		
	C/A VBP	\$ 6,847		
	rounding	\$ -		
	Total Other Resident Revenue	\$ 248,351	\$ -	\$ -

Interest Income

Account

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

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	MEALS	\$ -		
	TELEVISION INCOME	\$ -		
	CONCESSIONS / VENDING INCOME	\$ 1,091		
	RESIDENT LATE FEE REVENUE	\$ -		
	RESIDENT ATTORNEY FEE REVENUE	\$ -		
	TELEPHONE INCOME	\$ -		
	OTHER INCOME	\$ 142		
	OPTUM DIVIDENDS REVENUE	\$ 45,629		
	OPTUM OUTLIERS	\$ -		
	OTHER INCOME: DEFERRED REVENUE	\$ -		
	ALL DMHAS REVENUE	\$ -		
	Total Other Revenue	\$ 46,862	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2019	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	7,858
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,435,509
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	799,300
a. Prepaid Insurance	762,699			
b. Prepaid Property Taxes	35,099			
c. Prepaid Expenses Other	1,502			
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	(749,306)
Due From (to) Related Parties	2,263			
Other Owners reserves	(751,570)			
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	2,493,361
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost		\$	
	Accum. Depreciation	Net		
3. Buildings	*Historical Cost	342,818	\$	223,779
	Accum. Depreciation	119,039 Net		
4. Leasehold Improvements	*Historical Cost	645,076	\$	297,209
	Accum. Depreciation	347,867 Net		
5. Non-Movable Equipment	*Historical Cost		\$	
	Accum. Depreciation	Net		
6. Movable Equipment	*Historical Cost	1,144,442	\$	199,883
	Accum. Depreciation	944,559 Net		
7. Motor Vehicles	*Historical Cost	2,306	\$	
	Accum. Depreciation	2,306 Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
Construction in Progress				
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	720,871

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			\$ -

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

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

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

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

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

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

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2019	32	37
Account			Amount	
Total Brought Forward:			\$	3,214,232
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			\$	318,353
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	65,480
	Patient Trust Funds	62,925		
	Long Term Deposit - primecare	2,555		
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
	Name and Address	Amount	Loan Date	
7. Other Assets (<i>itemize</i>)			\$	

	See Schedule			
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	383,834
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	3,598,066

* 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	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2019	33	37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable			\$	433,469
2. Notes Payable (<i>itemize</i>)			\$	1,267,452
Working Capital Line of Credit		1,267,452		
See Schedule				
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)			\$	
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)			\$	498,611
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$	
6. Accrued Payroll Taxes Payable			\$	
7. Medicare Final Settlement Payable			\$	
8. Medicare Current Financing Payable			\$	
9. Mortgage Payable (<i>Current Portion</i>)			\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)			\$	
11. Accrued Income Taxes*			\$	
12. Other Current Liabilities (<i>itemize</i>)			\$	1,908,085
Related Party Payables		930,372		
Accrued Expenses		(6,386)		
Accrued Resident User Fees		288,311		
Accrued Workers Comp Expense		695,788	See Schedule	
A-13. Total Current Liabilities (Lines A1 thru 12)			\$	4,107,617

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Westside Care Center, LLC	License No. 2291	Report for Year Ended 9/30/2019	Page 34	of 37
Account				Amount
Total Brought Forward:				4,107,617
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>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$
Patient Trust Funds		62,925	62,925	
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 62,925
C. Total All Liabilities (Lines A-13 + B-5)				\$ 4,170,542

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

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2019	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	25,000
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(699,733)
6. Gain or Loss for Period			\$	102,256
	10/1/2018	thru 9/30/2019		
7. Total Net Worth			\$	(572,477)
C. Total Reserves and Net Worth			\$	(572,477)
D. Total Liabilities, Reserves, and Net Worth			\$	3,598,066

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2019	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2018			\$	
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	14,936,569
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	14,834,313
D. Net Income or Deficit			\$	102,256
E. Balance			\$	102,256
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	
Name and Address (<i>No., City, State, Zip</i>)		Title	Amount	
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. <i>Balance at End of Period</i>			\$	102,256
	09/30/19			

I. Preparer's/Reviewer's Certification

Name of Facility Westside Care Center, LLC	License No. 2291	Report for Year Ended 9/30/2019	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
iCare Management, LLC				
Address Address			Phone Number	
341 Bidwell Street, Manchester, CT 06040			860-570-2140	
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number	
Contact Email Address				