State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2022

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 ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☑ Other		
Report for Year Beginning 10/1/2021	Report for Year Ending 9/30/2022	

License Numbers:	CCNH	RHNS	Other	Medicare Provider
	2291			07-5252

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	78707		

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2022	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 Westside Care Center, LLC [facility name], for the cost report period beginning October 1, 2021 and ending September 30, 2022, 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) George Kingston			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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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 10/1/2021	To 9/30/2022
Address of Facility 349 Bidwell Street, Manchester, CT 06040				
Report Prepared By iCare Management, LLC	Phone Number 860-570-2140		Date 2/15/2023	

Item	Total	CCNH	RHNS	Other
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
860-647-9191	9/30/2022	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Westside Care Center, LLC	349 Bidwell Street, Manchester, CT 06040

License Numbers:	CCNH	RHNS	Other	Medicare Provider No.
	2291			07-5252

Type of Facility (Check appropriate box(es))

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

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.:
George Kingston	1327

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2022	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
Westside Care Center, LLC	349 Bidwell Street, Manchester, CT 06040	CT

Name of Partners/Members	Business Address	Title	% Owned
Executive Advisors, LLC	341 Bidwell St. Manchester, CT 06040	Member	47.5
Apex Advisors LLC	341 Bidwell St. Manchester, CT 06040	Member	47.5
Christopher Wright	341 Bidwell St. Manchester, CT 06040	Member	5

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2022	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

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Names of Stockholders Owning at Least 10% of Shares			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2022	3B	37

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ⊙ No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
See Attached.		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

* 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.

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

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
ADP, Inc., One ADP Drive MS-100, Augusta, GA 30909	○	⊙	Time Clocks and Payroll Punch Equip	06/01/10	60 months & automatic	13,548	13,548
Wells Fargo C/O GE Capital C/O Ricoh USA, P.O.Box 41564, Philadelphai, PA 19101	○	⊙	Copier	11/20/14	48 months	10,283	10,283
Mail Finance/Neopost New England, 25881 Newtwork Place, Chicago, IL 60673	○	⊙	Postage Meter Rental		Monthly	830	830
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total ***** 24,661

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

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General Information and Questionnaire
Accounting Basis

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 O'Connor, Davies LLP	100 Great Meadow Road, Ste 401, Wethersfield, CT 06109
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Taxes, financial statements, accounting support	$ 10,214
2		$
3		$
4		$
		Charge for Services Provided: $ 10,214

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

⊙ Yes ○ No 15D

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 iCare Health Management, LLC	860-570-2140
2 Robinson & Cole, LLP	860-275-8200
3 Various others (American Arbitration , Various Arbitration, Murtha Cullina)	
4	
5 iCare Health Management LLC	860-678-7775 & 860-570-2140

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

1 341 Bidwell Street, Manchester CT
2 280 Trumbull St, Hartford, CT
3
4
5 341 Bidwell Street, Manchester CT

Services Provided by This Firm (*describe fully*)

1	Lease and contract issues, general legal advice, Labor Law	$ 369
2	General legal advice, union funds advice, employment law	$
3	Employment Arbitrations, healthcare law & Conservatorships	$ 1,723
4		$
5	Collections	$ 0
		Charge for Services Provided: $ 2,092

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

⊙ Yes ○ No 15E

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total Other	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Other	Total	CCNH	RHNS	Other
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	162	162			162	162						
B. On last day of THIS report period	162	162							162	162		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	108	108			108	108						
B. As of midnight of THIS report period	121	121							121	121		
3. Total Number of Days Care Provided During Period												
A. Medicare	2,517	2,517			2,110	2,110			407	407		
B. Medicaid (Conn.)	40,725	40,725			30,258	30,258			10,467	10,467		
C. Medicaid (other states)												
D. Private Pay	112	112			83	83			29	29		
E. State SSI for RCH												
F. Other (Specify) Insurance	175	175			114	114			61	61		
G. Total Care Days During Period (3A thru F)	43,529	43,529			32,565	32,565			10,964	10,964		
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)**	43,529	43,529			32,565	32,565			10,964	10,964		

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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	Other	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Other	

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	Other
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	Other	R.C.H.	ICF-MR
No. of Residents	5	115		1				
Per Diem Rate								
a. One bed rm.	410.00	298.00		454.00				
b. Two bed rms.								
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	Other
A. Medicare - Part B	1,796	1,796		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,522	1,522		
2. Restorative Treatments	3,515	3,515		
C. Other	4,503	4,503		
D. ***Total Physical Therapy Treatments***	11,336	11,336		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	164	164		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	231	231		
2. Restorative Treatments	252	252		
C. Other	436	436		
D. ***Total Speech Therapy Treatments***	1,083	1,083		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,552	1,552		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,303	1,303		
2. Restorative Treatments	3,302	3,302		
C. Other	4,492	4,492		
D. ***Total Occupational Therapy Treatments***	10,649	10,649		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2022	10	37

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Other	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)	194,099	2,046				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	316,427	13,107				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	68,781	2,252				
c. Dietary Workers	430,215	21,759				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	53,013	1,643				
b. Other Maintenance Workers	48,496	2,056				
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	177,082	2,871				
b. RN						
1. Direct Care	497,704	6,614				
2. Administrative**	184,751	4,553				
c. LPN						
1. Direct Care	1,439,582	37,169				
2. Administrative**	43,862	1,107				
d. Aides and Attendants	2,331,759	98,906				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	179,838	7,870				
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	121,919	4,098				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	67,682	3,886				
A-13. Total Salary Expenditures	6,155,209	209,935				

* 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		Other	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
UNIT SECRETARIES SALARIES	$ -	-			$ -	-
MEDICAL RECORDS SALARIES	$ 15,496	894			$ -	-
CENTRAL SUPPLY SALARIES	$ 2,120	128			$ -	-
RESPIRATORY THERAPY SALARIES	$ -	-			$ -	-
PLANT SECURITY SALARIES	$ 50,067	2,864			$ -	-
MEDICAL RECORDS SALARIES SPCL	$ -	-			$ -	-
Total	$ 67,682	3,886	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		Other	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
MEDICAL RECORDS CONTRACT SERVICE	$ 4,191	storage			$ -	-
ADMISSIONS C/S LABOR	$ 57,492	1,059			$ -	-
CENTRAL SUPPLY CONTRACT SERVICE	$ 7,655	208			$ -	-
ADMINISTRATIVE CONTRACT SERVICE LABOR	$ 117,093	3,013			$ -	-
RESPIRATORY THERAPY CONTRACT SERVICES	$ 370	7			$ -	-
PHYSICAL THERAPY C/S MEDICIAD	$ -	-			$ -	-
SPEECH THERAPY C/S Medicaid	$ -	-			$ -	-
OCCUPATIONAL THERAPY C/S MEDICIAD	$ -	-			$ -	-
Total	$ 186,802	4,287	$ -	-	$ -	-

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

Name of Facility	License No.	Report for Year Ended	Page	of
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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	Other							
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.

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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
Westside Care Center, LLC	2291	9/30/2022	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	Other							
Section III - Administrators* **										
George Kingston	187,464			same as employees less union funds	Administrator	1,966	A2			
Cori Knutsen	6,634			same as employees less union funds	Administrator	80	A2			
				same as employees less union funds	Administrator		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
Westside Care Center, LLC	2291	9/30/2022	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Other	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	29,225	236				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	180,518	3,458				
b. Other						
6. Social Worker	8,861	102				
7. Recreation Worker	12,331	Cable				Cable
8. Physicians						
a. Medical Director (entire facility)	36,000	350				
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	8,517	9				
9. Speech Therapist						
a. Resident Care	34,760	666				
b. Other						
10. Occupational Therapist						
a. Resident Care	186,466	3,572				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	409,399	3,041				
2. Administrative***	128,556	2,271				
b. LPN						
1. Direct Care	68,896	923				
2. Administrative***						
c. Aides	2,130	152				
d. Other						
12. Other (Specify)						
See Attached Schedule	186,802	4,287				
B-13 Total Fees Paid in Lieu of Salaries	1,292,461	19,067				

* 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
Westside Care Center, LLC	2291	9/30/2022	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Tocuhpoints Therapy	Therapy for residents, also Therapy for Workers comp for staff	⊙	○	Common Ownership
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver	Shared Employees	⊙	○	Common Ownership
Pharm Scripts	Pharmacy Contract	○	⊙	
Guardian Consulting Srv	Pharmacy Consulting	○	⊙	
Healthdrive Physician Services	Audiology, Dental and Podiatry	○	⊙	
IPC Hospitalists	Medical Director	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

* 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
Westside Care Center, LLC	2291	9/30/2022	15	37

Item		Total	CCNH	RHNS	Other
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	303,829	303,829		
2. Disability Insurance	$				
3. Unemployment Insurance	$				
4. Social Security (F.I.C.A.)	$	519,015	519,015		
5. Health Insurance	$	1,048,961	1,048,961		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	357,468	357,468		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	41,686	41,686		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	207,411	207,411		
d. Accounting and Auditing	$	10,214	10,214		
e. Legal (*Services should be fully described on Page 7)*	$	2,092	2,092		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	21,289	21,289		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	30,555	30,555		
2. Cellular Phones	$	1,296	1,296		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	862,476	862,476		
Subtotal	$	3,406,292	3,406,292		

* 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	Other
UNION TRAINING	$ 41,686		$ -
Total	$ 41,686	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	Other
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
Westside Care Center, LLC	2291	9/30/2022	16	37

Item		Total	CCNH	RHNS	Other
Subtotals Brought Forward:		3,406,292	3,406,292		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	791	791		
5. Education Expenses Related to Seminars and Conventions	$	2,032	2,032		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$	326	326		
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	22,425	22,425		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	13,416	13,416		
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	$	3,646	3,646		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	10,968	10,968		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	777	777		
10. Contributions***	$	250	250		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	147,125	147,125		
12. Administrative Management Services**	$	414,176	414,176		
13. Other (*Specify*)	$	52,431	52,431		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	4,074,656	4,074,656		

* 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	Other
MEALS	$ 326		$ -
Total Other Travel and Entertainment	$ 326	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	Other
COMMUNICATIONS SPECIAL EVENTS	$ 13,416		$ -
Total Other Advertising	$ 13,416	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	Other
ALTCFM			
CAHCF Dues	$ 10,968		$ -
OTHER DUES			
Total Dues	$ 10,968	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	Other
CONTRIBUTIONS	$ 250		$ -
Total Contributions	$ 250	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	Other
SOCIAL SERVICE SUPPLIES	$ -		$ -
SOC SVC MINOR EQUIPMENT	$ -		$ -
ADMINISTRATIVE MINOR EQUIPMENT	$ 5,007		$ -
EMPLOYEE RELATIONS	$ 3,200		$ -
EMPLOYEE RELATIONS-OTHER	$ 195		$ -
PERMITS & LICENSES	$ 1,970		$ -
VOLUNTEER EXPENSE	$ -		$ -
BANK FEES	$ 6,250		$ -
CMS REVISIT USER FEES	$ -		$ -
PENALTIES	$ 23,725		$ -
LATE FEES	$ 932		$ -
INTERNET EXPENSES	$ 11,153		$ -
Rounding	$ -		
Total Other Administrative and General	$ 52,431	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility Westside Care Center, LLC	License No. 2291	Report for Year Ended 9/30/2022	Page 17 | of 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	414,176	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	162,722	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	39,115	MANAGEMENT FEES- INDIRECT CARE	Pg 20 k

*** 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. 9/2018

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
Westside Care Center, LLC	2291	9/30/2022	18 | 37

Item		Total	CCNH	RHNS	Other
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	353,723	353,723		
2. Non-Food Supplies	$	55,030	55,030		
3. Other (*Specify*) DIETARY SUPPLEMENTS	$	22,303	22,303		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	37,512	37,512		
c. Other (*Specify*) DIETARY MINOR EQUIPMENT	$	16,735	16,735		
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	485,302	485,302		

2E. Dietary Questionnaire		Total	CCNH	RHNS	Other
F. Resident Meals:	Total no. of meals served per day:*	358	358		

G.	Is cost of employee meals included in 2D?	○ Yes	⊙ No	
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 meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	○ Yes	⊙ No	If yes, specify cost.
K.	Is any revenue collected from these people?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
N.	Is any revenue collected from employees?	○ Yes	⊙ 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.

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CSP-19 Rev. 9/2018

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	9/30/2022	19 | 37

Item		Total	CCNH	RHNS	Other
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. $				
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)*	$	501,503	501,503		
c. Other (*Specify*) LAUNDRY MINOR EQUIPMENT	$	899	899		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	502,402	502,402		

3E.	Laundry Questionnaire			
F.	Is cost of employee laundry included in 3D?	○ Yes	⊙ No	If yes, specify cost.
G.	Did you receive revenue from employees?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
J.	Did you receive revenue from these people?	○ Yes	⊙ 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.

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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
Westside Care Center, LLC	2291	9/30/2022	20	37

Item			Total	CCNH	RHNS	Other
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	28,444	28,444		
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$	512,287	512,287		
C. Other (*Specify*)		$				
HOUSEKEEPING MINOR EQUIPMENT						
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	540,731	540,731		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	118,718	118,718		
PHARMACY						
b. Medicine Cabinet Drugs		$	4,112	4,112		
c. Medical and Therapeutic Supplies		$	119,721	119,721		
d. Ambulance/Limousine***		$	9,922	9,922		
e. Oxygen						
1. For Emergency Use		$	1,250	1,250		
2. Other***		$				
f. X-rays and Related Radiological Procedures***		$	2,361	2,361		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	7,332	7,332		
i. Recreation		$				
j. Direct Management Services*		$	162,722	162,722		
k. Indirect Management Services*		$	39,115	39,115		
l. Other (Specify)****		$	85,990	85,990		
See Attached Schedule						
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	551,243	551,243		

* 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	Other
NURSING ADMIN SUPPLIES	$ 497		$ -
NURSING MINOR EQUIP	$ 2,524		$ -
MEDICAL RECORDS SUPPLIES	$ (367)		$ -
MEDICAL RECORDS MINOR EQUIPMENT	$ -		$ -
NON-COVERED PPS DR. VISITS	$ -		$ -
RESIDENT CARE SUPPLIES	$ 265		$ -
CENTRAL SUPPLY MINOR EQUIPMENT	$ 16,541		$ -
PERSONAL CARE SUPPLIES	$ 2,795		$ -
INCONTINENCY SUPPLIES	$ 53		$ -
VACCINE RESIDENTS	$ 6,546		$ -
PATIENT SPECIAL NEEDS	$ 586		$ -
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	$ 23,515		$ -
EQUIPMENT RENTAL: AIDS UNIT	$ -		$ -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	$ 248		$ -
PEN THERAPY FOOD NOT BILLABLE TO PART B	$ 362		$ -
HI LOW BED RENTAL & MATTRESSES	$ -		$ -
IV THERAPY SUPPLIES	$ 24,977		$ -
IV THERAPY CONTRACT SERVICE	$ -		$ -
MEDICAL WASTE CONTRACT SERVICE	$ 1,522		$ -
ACTIVITIES SUPPLIES	$ 2,902		$ -
ACTIVITIES MINOR EQUIPMENT	$ 3,024		$ -
ADMISSIONS SUPPLIES	$ -		$ -
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS			
STRIKE COSTS NON REIMBURSABLE	$ -		$ -
COVID NON REIMBURSABLE	$ -		$ -
Total Other Resident Care	$ 85,990	$ -	$ -

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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
Westside Care Center, LLC	2291	9/30/2022	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	Other	Pg	Line
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	○	⊙	VENDOR	Housekeeping Services	512,287			20	4b
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	○	⊙	VENDOR	Laundry Services	501,503			19	3b
Eagle Elevator		○	⊙	VENDOR	Elevator Contract	6,435			22	6F
Brightview Landscapes LLC		○	⊙	VENDOR	Landscaping	8,795			22	6F
Peter Marcue		○	⊙	VENDOR	Snow Removal	22,100			22	6F
CWPM LLC		○	⊙	VENDOR	Trash removal	33,063			22	6F
Facility Complaince		○	⊙	VENDOR	Plant Contract Services				22	6F
American HealthTech	P.O. Box 9001006, Louisville, KY 40290	○	⊙	VENDOR	Software Maintenance Contract	15,787			16	M11
Automatic Data Processing		○	⊙	VENDOR	Payroll Services	40,805			16	M11
National Datacare Corp		○	⊙	VENDOR	Resident Trust Software	5,919			16	M11
Prime Care Technologuy services		○	⊙	VENDOR	Computer Consulting Services	30,103			16	M11
Priotiry Express		○	⊙	VENDOR	Courier Services	3,324			16	M11
Point Right Inc		○	⊙	VENDOR	Nursing Software	5,011			16	M11
		○	⊙	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).

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CSP-22 Rev. 6/95

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	9/30/2022	22 | 37

Item		Total	CCNH	RHNS	Other
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	45,456	45,456		
b. Heat	$	34,364	34,364		
c. Light & Power	$	136,257	136,257		
d. Water	$	56,901	56,901		
e. Equipment Lease (*Provide detail on page 6*)	$	24,661	24,661		
f. Other (*itemize*)	$	122,529	122,529		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	420,168	420,168		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	23,260	23,260		
c. Non-Movable Equipment	$				
d. Movable Equipment	$	57,866	57,866		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	81,126	81,126		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	53,926	53,926		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	53,926	53,926		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	295,739	295,739		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	128,095	128,095		
c. Personal property taxes	$	13,696	13,696		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	572,581	572,581		

* 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	Other
PLANT SUPPLIES	$ 10,653		$ -
PLANT CONTRACT SERVICE LABOR	$ 9,442		$ -
ELEVATOR CONTRACT SERVICE	$ 6,435		$ -
FIRE/SPRINKLER CONTRACT SERVICE	$ 8,932		$ -
LANDSCAPING CONTRACT SERVICE	$ 8,795		$ -
SNOW REMOVAL CONTRACT SERVICE	$ 22,100		$ -
TRASH REMOVAL CONTRACT SERVICE	$ 33,063		$ -
PLANT (POOL) CONTRACT SERVICES OTHER	$ -		$ -
SECURITY CONTRACT SERVICE	$ -		$ -
PLANT CONTRACT SERVICE OTHER	$ 14,147		$ -
PLANT MINOR EQUIPMENT	$ 6,561		$ -
RENT AUTO	$ -		$ -
RENT EQUIPMENT	$ 2,400		$ -
RENT OTHER	$ -		$ -
Total Other Repairs and Maintenance	$ 122,529	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2022	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	342,818		342,818	169,651			23,260	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								23,260
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								

	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					1,239,671		1,239,671	1,045,907			55,306	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative					5,112						85	
d. Standard Resident					32,522						2,475	
e. Specialized Resident												
Total Acquired during this report period					37,634						2,561	
D-3. Subtotal												57,781
E. ***Total Depreciation***												81,041

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**

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One Movable Category	Cost	Useful Life	Depreciation	
Additions:						
12/29/2021	Patient Lift: Direct Supply	Standard Resident	$ 3,348	120	$ 251	
12/8/2021	Repair Hot Water Heater: Saucier Mechanical	Standard Resident	$ 2,645	120	$ 198	
3/18/2022	Beds: Medline	Standard Resident	$ 8,658	60	$ 866	
4/2/2022	Beds: Medline	Standard Resident	$ 9,326	60	$ 777	
4/27/2022	Mattress: Direct Supply	Standard Resident	$ 3,069	60	$ 256	
3/4/2022	Dryer Upgrade: Mark's Appliance & CSC Servies	Standard Resident	$ 2,542	120	$ 127	
7/12/2022	Upgrade Internet: Primecare & Comtech21	Administrative	$ 5,112	36	$ 85	
9/12/2022	Air Purifier: Direct Supply	Standard Resident	$ 2,934	60	$ -	
		Standard Resident				
		Standard Resident				
		Standard Resident				
		Standard Resident				
		Standard Resident				
		Standard Resident				
		Standard Resident				
		Standard Resident				
		Standard Resident				
		Standard Resident				
		Standard Resident				
		Standard Resident				
Total additions for Movable Equipment			$ 37,634		$ 2,561	*
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:					
9/28/2021	Broken Sewage Pipe Clean Up: Servpro	$ 3,189	240	$ 159	
9/29/2021	Repair Window Frames: Target 10	$ 7,272	180	$ 485	
10/11/2021	Flooring: Target 10 Construction	$ 7,125	120	$ 653	
3/21/2022	Plumbing: Saucier Mechanical	$ 4,410	300	$ 88	
5/1/2022	Upgrade Fire Sprinkler: Facilities Complianc	$ 4,701	300	$ 63	
9/21/2022	Reapair AC-Condenstate: Saucier Mechanical	$ 4,974	120	-	
7/13/2022	Replace Doors: Target 10 Construction	$ 21,988	120	$ 366	
Total additions for Leasehold Improvement		$ 53,658		$ 1,815	*
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
Westside Care Center, LLC	2291	9/30/2022	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				803,050	458,164			52,111	
2. Disposals (attach schedule)									
3. Acquired during this report period									
(attach schedule)				53,658				1,815	
C-4. Subtotal									53,926
D. ***Total Amortization***									53,926

* 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
Westside Care Center, LLC	2291	9/30/2022	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	04/01/99
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 Trinity Hill SNF, LLC	151 Hillside Ave, Hartford, CT	08/09/17	15 year with 2	308,383

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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CSP-26 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Westside Care Center, LLC	2291	9/30/2022	26 | 37

Item	Total	CCNH	RHNS	Other
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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CSP-27 Rev. 6/95

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	9/30/2022	27 | 37

Item	Total	CCNH	RHNS	Other
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*) $	4,895	4,895		
INTEREST				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	4,895	4,895		
14. Insurance				
a. Insurance on Property (buildings only) $	12,110	12,110		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	107,683	107,683		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $	17,696	17,696		
Other insurance, crime				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	137,489	137,489		
15. ***Total All Expenditures (A-13 thru C-14)*** $	14,737,138	14,737,138		

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CSP-28 Rev. 9/2018

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Westside Care Center, LLC	2291	9/30/2022	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
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.	15	C	Bad Debts $	207,411	207,411		
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.	16	m3	Unallowable Advertising * $	13,416	13,416		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	24,657	24,657		
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) $	245,483	245,483		

* 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	Other
Total Other Salaries Adjustment			$ -	$ -	$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
16a		PENALTIES	$ 23,725		$ -
16a		LATE FEES	$ 932		$ -
16a		PRIOR PERIOD EXPENSES			
		rounding			
Total Other A&G Adjustments			$ 24,657	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Westside Care Center, LLC	2291	9/30/2022	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
			Subtotals Brought Forward $	245,483	245,483		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs $				
28.	20	5d	Ambulance/Limousine $	9,922	9,922		
29.	20	5f	X-rays, etc $	2,361	2,361		
30.	20	5h	Laboratory $	7,332	7,332		
31.			Medical Supplies $				
32.			Oxygen (non emergency) $				
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $				
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)***		$	265,098	265,098		

*** 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

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Other
20	5J	Non Covered PPS Visits	-		-
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)	-		
13	B9A	ST- Resident Care (for outpatent therapy - see schedule)	-		
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)	-		
Total Other Ancillary Costs			$ -	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
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	Other
Total Other Adjustments			$ -	$ -	$ -

Schedule of Other - Direct Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Other Adjustments			$ -	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Westside Care Center, LLC	2291	9/30/2022	30 | 37

Item		Total	CCNH	RHNS	Other
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	11,962,706	11,962,706		
b. Medicaid Room and Board Contractual Allowance **	$				
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,483,899	1,483,899		
b. Medicare Room and Board Contractual Allowance **	$				
4. a. Private-Pay Residents and Other	$	145,856	145,856		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	59,353	59,353		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(59,253)	(59,253)		
c. Prescription Drugs - Non-Medicare	$	49,012	49,012		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(49,012)	(49,012)		
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	$	126,404	126,404		
b. Physical Therapy - Medicare Contractual Allowance **	$	(105,691)	(105,691)		
c. Physical Therapy - Non-Medicare	$	200,781	200,781		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(200,781)	(200,781)		
4. a. Speech Therapy - Medicare	$	24,884	24,884		
b. Speech Therapy - Medicare Contractual Allowance **	$	(17,823)	(17,823)		
c. Speech Therapy - Non-Medicare	$	43,232	43,232		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(43,232)	(43,232)		
5. a. Occupational Therapy - Medicare	$	138,066	138,066		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(115,936)	(115,936)		
c. Occupational Therapy - Non-Medicare	$	194,490	194,490		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(191,683)	(191,683)		
6. a. Other *(Specify)* - Medicare	$	30,188	30,188		
b. Other *(Specify)* - Non-Medicare	$	115,842	115,842		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	13,791,302	13,791,302		
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)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	104,196	104,196		
V. Total Other Revenue (1 thru 8)	$	104,196	104,196		
VI. Total All Revenue (III +V)	$	13,895,499	13,895,499		

* *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	Other
	Lab Medicare	$ 6,662		
	Lab Medicare CA	$ (6,662)		
	Oxygen Medicare	$ -		
	Oxygen Medicare CA	$ -		
	Equipment rental	$ 2,324		
	Equipment rental CA	$ (2,324)		
	Pen Therapy	$ -		
	Pen Therapy CA	$ -		
	Therapy Beds Medicare	$ -		
	Therapy Beds Medicare CA	$ -		
	Radiology Medicare	$ 2,013		
	Radiology Medicare CA	$ (2,013)		
	IV Therapy	$ 17,088		
	IV Therapy CA	$ (17,088)		
	Medical Transportation	$ -		
	Medical Transportation CA	$ -		
	Glucose testing	$ -		
	Glucose testing CA	$ -		
	Outpatient therapy Medicare	$ -		
	MEDICAID COVID REVENUE	$ -		
	CRF MEDICAID REVENUE	$ 87,326		
	MEDICAID WAGE & ENHANCEMENT RESERVE	$ (57,139)		
Total Other Resident Revenue - Medicare		$ 30,188	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Other
	Lab	4,950		
	Lab CA	(4,950)		
	Oxygen	$ -		$ -
	Oxygen CA	$ -		$ -
	Equipment rental	$ 5,549		
	Equipment rental CA	$ (5,549)		
	Pen Therapy	$ -		
	Pen Therapy CA	$ -		
	Therapy Beds	$ -		
	Therapy Beds CA	$ -		
	Radiology	$ 126		
	Radiology CA	$ (126)		
	Medical Transportation	$ -		
	Medical Transportation CA	$ -		
	Glucose Testing	$ -		
	Glucose Testing CA	$ -		
	IV therapy	$ 39,072		$ -
	IV therapy CA	$ (39,072)		$ -
	Flu shot revenue	$ 714		
	Outpatient therapy	$ -		
	prior period revenue	$ 12,178		
	Optum B	$ 207,881		
	Optum B CA	$ (104,931)		
	C/A VBP	$ -		
	rounding	$ 0		
Total Other Resident Revenue		$ 115,842	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	Other
	INTEREST INCOME		$ -		
Total Interest Income			$ -	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Other
	MEALS	$ -		
	TELEVISION INCOME	$ -		
	OTHER INCOME: DMHAS OPERATING REVENUE	$ -		
	OTHER INCOME: DMHAS ORGANIZATIONAL REV	$ -		
	OTHER INCOME: DEFERRED REVENUE	$ 6,479		
	MEDICARE COVID STIMULUS REVENUE	$ -		
	CONCESSIONS / VENDING INCOME	$ 643		
	RESIDENT LATE FEE REVENUE	$ -		
	RESIDENT ATTORNEY FEE REVENUE	$ -		
	TELEPHONE INCOME	$ -		
	OTHER INCOME	$ -		
	OPTUM DIVIDENDS REVENUE	$ 9,700		
	OPTUM OUTLIERS	$ -		
	HHS GENERAL FUND REVENUE	$ -		
	HHS INFECTION CONTROL REVENUE	$ 87,374		
	CARES ACT REVENUE	$ -		
	EMPLOYEE TESTING REVENUE	$ -		
	COVID ECHO TRAINING REVENUE	$ -		
Total Other Revenue		$ 104,196	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2022	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 24,425
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 3,334,411
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 122,339
a. Prepaid Insurance		84,450		
b. Prepaid Property Taxes		34,513		
c. Prepaid Expenses Other		3,376		
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ (1,915,965)
Due From (to) Related Parties		(623,764)		
Other Owners reserves		(1,292,202)		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,565,210
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost	342,818		$ 149,907
	Accum. Depreciation	192,910	Net	
4. Leasehold Improvements	*Historical Cost	856,708		$ 344,619
	Accum. Depreciation	512,089	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	1,277,305		$ 173,532
	Accum. Depreciation	1,103,773	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
Construction in Progress				
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 668,058

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			$ -

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

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

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

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2022	32	37

Account				Amount
			Total Brought Forward:	$ 2,233,269
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				$ 589,961
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$ 107,561
Patient Trust Funds		91,006		
Long Term Deposit - primecare		16,555		
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 697,522
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 2,930,790

* 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
Westside Care Center, LLC	2291	9/30/2022	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 1,143,764
	2. Notes Payable (*itemize*)				$ 211,045
	Working Capital Line of Credit			211,045	
	See Schedule				
	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*)				$ 611,629
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$
	7. Medicare Final Settlement Payable				$
	8. Medicare Current Financing Payable				$
	9. Mortgage Payable (*Current Portion*)				$
	10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
	11. Accrued Income Taxes*				$
	12. Other Current Liabilities (*itemize*)				$ 1,400,492
	Related Party Payables			920,389	
	Accrued Expenses			(34,315)	
	Accrued Resident User Fees			221,257	
	Accrued Workers Comp Expense			293,162 See Schedule	
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 3,366,930

* 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
Westside Care Center, LLC	2291	9/30/2022	34	37

Account				Amount
			Total Brought Forward:	3,366,930
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*)				$ 91,006
Patient Trust Funds	91,006			
See Schedule				
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ 91,006
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 3,457,936

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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	9/30/2022	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. 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	$ 289,494
	6. Gain or Loss for Period 10/1/2021 thru 9/30/2022	$ (841,640)
	7. Total Net Worth	$ (527,146)
C.	***Total Reserves and Net Worth***	$ (527,146)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 2,930,790

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2022	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2021			$
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 13,895,499
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 14,737,138
D.	Net Income or Deficit			$ (841,640)
E.	Balance			$ (841,640)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period***	09/30/22		$ (841,640)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2022	37	37

Check appropriate category

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

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	
iCare Management, LLC	
Addres Address	Phone Number
341 Bidwell Street, Manchester, CT 06040	860-570-2140
Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Kartik Patel	860-570-2140
Contact Email Address	
kpatel@icarehn.com	