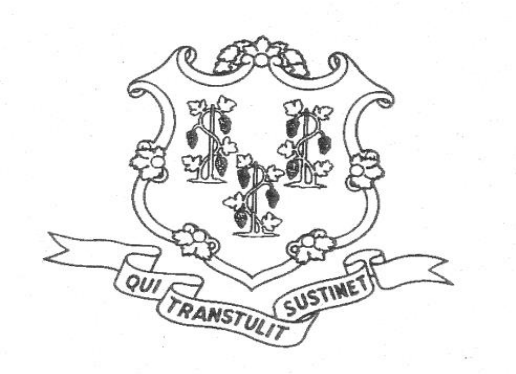
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2023

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 (CCNH) & RHNS Combined ☑ (Specify) ☑ Other	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

License Numbers:	CCNH / RHNS	(Specify)	Other	Medicare Provider
	2291			07-5252

Medicaid Provider Numbers:	CCNH / RHNS	(Specify)	Other
	78707		

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2023	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, 2022 and ending September 30, 2023, 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) Ashely Frame			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 10/1/2022	To 9/30/2023
Address of Facility 349 Bidwell Street, Manchester, CT 06040				
Report Prepared By iCare Management, LLC	Phone Number 860-570-2140		Date 2/15/2024	

Item		Total	CCNH / RHNS	(Specify)	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	9/30/2023	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	(Specify)	Other	Medicare Provider No.
	2291			07-5252

Type of Facility (Check appropriate box(es))

☐ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined ☑ (Specify) ☑ 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.:
Ashely Frame	2169

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	9/30/2023	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	9/30/2023	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	9/30/2023	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
Westside Care Center, LLC	2291	9/30/2023	4	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ⊙ No

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
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
Westside Care Center, LLC	2291	9/30/2023	5	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 (*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
Other Lines of Business

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2023	6	37

Square footage of entire facility.	0

Outpatient Therapy

Does the Facility provide outpatient therapy services?	No

If yes, please complete the following:

	Square footage of therapy space.

Meals on Wheels

Does the facility provide Meals on Wheels?	No

If yes, please complete the following:

	Square footage of kitchen	
	Number of meals served per week	
No	Are meals included in meals served on page 18 of the Annual Report?	
No	Are direct costs included in the Annual Report?	
	If yes, please state where costs are reported.	
No	Are drivers for the program included in the facility's payroll?	
	If yes, please complete the following:	
		Amount Reported
		Annual Report page and line
	Please state the salary amounts of specific cooks and/or dietary aides	
	Please state where the cooks and/or dietary aides are reported in the Annual Report	

Apartments, Independent Living, Assisted Living

Does the facility have apartments, independent living, and/or assisted living?	No

If yes, please complete the following:

	Square footage of apartments
	Square footage of independent living
	Square footage of assisted living
	Please identify the services provided:

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General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility	License No.	Report for Year Ended	Page	of
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Child Day Care

Does the Facility provide Child Day Care?	No

If yes, please complete the following:

	Square footage of child day care space.
	Average number of daily participants.
	Number of meals per day provided to child day care.
	Nature of services provided:

Adult Day Care

Does the Facility provide Adult Day Care?	No

If yes, please complete the following:

	Square footage of adult day care space.
	Please state where it is located in relation to the facility.
	Average number of daily participants.
	Number of meals per day provided to adult day care.
	Nature of services provided:

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2023	8	37

	Total All Levels	Total CCNH / RHNS Level	Total (Specify)	Total Other	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH / RHNS	(Specify)	Other	Total	CCNH / RHNS	(Specify)	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	121	121			121	121						
B. As of midnight of THIS report period	129	129							129	129		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,826	1,826			1,350	1,350			476	476		
B. Medicaid (Conn.)	41,666	41,666			30,956	30,956			10,710	10,710		
C. Medicaid (other states)												
D. Private Pay	455	455			363	363			92	92		
E. State SSI for RCH												
F. Other (Specify) Insurance	104	104			104	104						
G. Total Care Days During Period (3A thru F)	44,051	44,051			32,773	32,773			11,278	11,278		
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)**	44,051	44,051			32,773	32,773			11,278	11,278		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2023	9	37

4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

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

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

Change in Resident Days	CCNH / RHNS	(Specify)	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 / RHNS	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	Other	R.C.H.	ICF-MR
No. of Residents	6	123		7				
Per Diem Rate								
a. One bed rm.	490.00	######		508.00				
b. Two bed rms.								
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	(Specify)	Outpatient	Other
A. Medicare - Part B	2,559	2,559			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	1,646	1,646			
2. Restorative Treatments	4,457	4,457			
C. Other	3,837	3,837			
D. ***Total Physical Therapy Treatments***	12,499	12,499			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	265	265			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	228	228			
2. Restorative Treatments	257	257			
C. Other	325	325			
D. ***Total Speech Therapy Treatments***	1,075	1,075			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	1,451	1,451			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	1,017	1,017			
2. Restorative Treatments	4,272	4,272			
C. Other	3,174	3,174			
D. ***Total Occupational Therapy Treatments***	9,914	9,914			

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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	9/30/2023	10	37

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

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	Other	Adjustment	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)	213,114		2,086						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	320,113		12,874						
5. Dietary Service									
a. Head Dietitian									
b. Food Service Supervisor	67,118		2,022						
c. Dietary Workers	445,692		22,249						
6. Housekeeping Service									
a. Head Housekeeper									
b. Other Housekeeping Workers									
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance	68,705		2,073						
b. Other Maintenance Workers	53,383		2,252						
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	258,559		4,032						
b. RN									
1. Direct Care	484,527		7,043						
2. Administrative**	(317)		15						
c. LPN									
1. Direct Care	1,431,222		32,964						
2. Administrative**	266,465		5,925						
d. Aides and Attendants	2,492,521		104,044						
e. Physical Therapists									
f. Speech Therapists									
g. Occupational Therapists									
h. Recreation Workers	151,688		6,449						
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	71,279		2,482						
n. Marketing									
o. Other (Specify)									
See Attached Schedule	96,112		5,246						
A-13. Total Salary Expenditures	6,420,181		211,755						

* 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 in the Adjustment column.

Schedule of Other Salaries and Wages (Page 10)

	CCNH / RHNS			(Specify)			Other		
Position	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**
UNIT SECRETARIES SALARIES	$ -		-				$ -		-
MEDICAL RECORDS SALARIES	$ 37,726		2,053				$ -		-
CENTRAL SUPPLY SALARIES	$ -		-				$ -		-
RESPIRATORY THERAPY SALARIES	$ -		-				$ -		-
PLANT SECURITY SALARIES	$ 58,387		3,193				$ -		-
MEDICAL RECORDS SALARIES SPCL	$ -		-				$ -		-
Total	$ 96,112	$ -	5,246	$ -	$ -	-	$ -	$ -	-

Schedule of Other Fees (Page 13)

	CCNH / RHNS			(Specify)			Other		
Service	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**
MEDICAL RECORDS CONTRACT SERVICE	$ 4,610		Storage				$ -		Storage
ADMISSIONS C/S LABOR	$ 67,647		1,235				$ -		-
CENTRAL SUPPLY CONTRACT SERVICE	$ 7,966		205				$ -		-
ADMINISTRATIVE CONTRACT SERVICE LABOR	$ 86,750		2,111				$ -		-
RESPIRATORY THERAPY CONTRACT SERVICES	$ 508		6				$ -		-
PHYSICAL THERAPY C/S MEDICIAD	$ -		-				$ -		-
SPEECH THERAPY C/S Medicaid	$ -		-				$ -		-
OCCUPATIONAL THERAPY C/S MEDICIAD	$ -	-	-				$ -		-
Total	$ 167,481	$ -	3,557	$ -	$ -	-	$ -	$ -	-

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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
Westside Care Center, LLC	2291	9/30/2023	11	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	(Specify)	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	9/30/2023	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	(Specify)	Other							
Section III - Administrators* **										
George Kingston	213,114			Administrator		2,086	same as empl			
				Administrator			same as empl			
				Administrator			same as empl			
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	9/30/2023	13	37

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	Other	Adjustment	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	29,976		249						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	224,722		4,305						
b. Other									
6. Social Worker	74,969		1,036						
7. Recreation Worker	13,127		2 Hours +Ca						
8. Physicians									
a. Medical Director (entire facility)	36,000		302						
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	5,734		17						
9. Speech Therapist									
a. Resident Care	31,736		608						
b. Other									
10. Occupational Therapist									
a. Resident Care	180,733		3,462						
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	323,795		2,838						
2. Administrative***	18,823		325						
b. LPN									
1. Direct Care	261,318		3,704						
2. Administrative***									
c. Aides	920		24						
d. Other									
12. Other (Specify)									
See Attached Schedule	167,481		3,557						
B-13 Total Fees Paid in Lieu of Salaries	1,369,332		20,427						

* 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 in the Adjustment column.

*** 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	9/30/2023	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	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
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		○	⊙	

* 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	9/30/2023					15	37

Item		Total Including Adjustment	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	$	131,501	131,501					
2. Disability Insurance	$							
3. Unemployment Insurance	$							
4. Social Security (F.I.C.A.)	$	529,610	529,610					
5. Health Insurance	$	1,107,922	1,107,922					
6. Life Insurance (employees only)								
(not-owners and not-operators)	$							
7. Pensions (Non-Discriminatory)	$	395,246	395,246					
(not-owners and not-operators)								
8. Uniform Allowance	$							
9. Other (*Specify*)	$	39,217	39,217					
See Attached Schedule								
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$							
c. Bad Debts*	$	554,611	554,611					
d. Accounting and Auditing	$	41,322	41,322					
e. Legal (*Services should be fully described on Page 15b)*	$	2,423	2,423					
f. Insurance on Lives of Owners and Operators (*Specify*)*	$							
g. Office Supplies	$	17,785	17,785					
h. Telephone and Cellular Phones								
1. Telephone & Pagers	$	52,415	52,415					
2. Cellular Phones	$	960	960					
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	$	883,568	883,568					
Subtotal	$	3,756,581	3,756,581					

* Facility should self-disallow the expense in the Adjustment column.

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
UNION TRAINING	$ 39,217				$ -	
Total	$ 39,217	$ -	$ -	$ -	$ -	$ -

Schedule of Other Taxes

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Total	$ -	$ -	$ -	$ -	$ -	$ -

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2023	15b	37

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Plante & Moran, PLLC	PO Box 307 3000 Town Center, Suite 100 Southfield, MI 48075
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Taxes, financial statements, accounting support	$ 41,322
2		$
3		$
4		$
	Charge for Services Provided	$ 41,322

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 Senior Care Valiation LLC	
2 Murtha Cullina LLP	
3 Various others (American Arbitration , Various Arbitration)	
4	
5	

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	Lease and contract issues, general legal advice, Labor Law	$ 1,000
2	General legal advice, union funds advice, employment law	$ 1,151
3	Employment Arbitrations, healthcare law & Conservatorships	$ 272
4		$
5	Collections	$ (0)
	Charge for Services Provided	$ 2,423

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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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	9/30/2023	16	37

Item		Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Subtotals Brought Forward:		3,756,581	3,756,581					
l. Travel and Entertainment								
1. Resident Travel and Entertainment	$							
2. Holiday Parties for Staff	$	430	430					
3. Gifts to Staff and Residents	$	52	52					
4. Employee Travel	$	1,231	1,231					
5. Education Expenses Related to Seminars and Conventions	$	1,478	1,478					
6. Automobile Expense (*not purchase or depreciation*)	$							
7. Other (*Specify*)	$	543	543					
See Attached Schedule								
m. Other Administrative and General Expenses								
1. Advertising Help Wanted (*all such expenses*)	$	24,928	24,928					
2. Advertising Telephone Directory (*all such expenses*)***	$							
3. Advertising Other (*Specify*)***	$	13,620	13,620					
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	$	3,856	3,856					
* 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	$	452	452					
10. Contributions***	$	200	200					
See Attached Schedule								
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	131,454	131,454					
12. Administrative Management Services**	$	443,265	443,265					
13. Other (*Specify*) See Attached Schedule	$	184,396	184,396					
C-14 Total Administrative & General Expenditures	$	4,573,453	4,573,453					

* 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 expensein the Adjustment column.

Schedule of Other Travel and Entertainment

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
MEALS	$ 543				$ -	
Total Other Travel and Entertainment	$ 543	$ -	$ -	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
COMMUNICATIONS SPECIAL EVENTS	$ 13,620				$ -	
Total Other Advertising	$ 13,620	$ -	$ -	$ -	$ -	$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
ALTCFM						
CAHCF Dues	$ 10,968				$ -	
OTHER DUES						
Total Dues	$ 10,968	$ -	$ -	$ -	$ -	$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
CONTRIBUTIONS	$ 200				$ -	
Total Contributions	$ 200	$ -	$ -	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
SOCIAL SERVICE SUPPLIES	$ -				$ -	
SOC SVC MINOR EQUIPMENT	$ -				$ -	
ADMINISTRATIVE MINOR EQUIPMENT	$ 4,289				$ -	
EMPLOYEE RELATIONS	$ 3,618				$ -	
EMPLOYEE RELATIONS-OTHER	$ 314				$ -	
PERMITS & LICENSES	$ 1,635				$ -	
VOLUNTEER EXPENSE	$ -				$ -	
BANK FEES	$ 7,949				$ -	
CMS REVISIT USER FEES	$ -				$ -	
PENALTIES	$ 147,152				$ -	
LATE FEES	$ 417				$ -	
INTERNET EXPENSES	$ 19,020				$ -	
Rounding	$ -					
Total Other Administrative and General	$ 184,396	$ -	$ -	$ -	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Westside Care Center, LLC	2291	9/30/2023	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	443,265	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	142,379	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	35,277	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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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	9/30/2023	18	37

Item		Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	$	302,068	302,068					
2. Non-Food Supplies	$	51,056	51,056					
3. Other (*Specify*) DIETARY SUPPLEMENTS	$	16,044	16,044					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	41,312	41,312					
c. Other (*Specify*) DIETARY MINOR EQUIPMENT	$	4,321	4,321					
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	414,802	414,802					

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

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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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	9/30/2023	19	37

Item		Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
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. $	145	145					
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)*	$	511,219	511,219					
c. Other (*Specify*) LAUNDRY MINOR EQUIPMENT	$	296	296					
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	511,659	511,659					

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	9/30/2023					20	37

Item			Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
4. Housekeeping	Sq. Ft. Serviced by Personnel								
a. In-House Care									
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	26,443	26,443					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel								
	Amt.	$	547,943	547,943					
C. Other (*Specify*) HOUSEKEEPING MINOR EQUIPMENT		$							
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	574,386	574,386					
5. Resident Care (Supplies)**									
a. Prescription Drugs***									
1. Own Pharmacy		$							
2. Purchased from PHARMACY		$	126,558	126,558					
b. Medicine Cabinet Drugs		$	6,913	6,913					
c. Medical and Therapeutic Supplies		$	96,317	96,317					
d. Ambulance/Limousine***		$	12,462	12,462					
e. Oxygen									
1. For Emergency Use		$	904	904					
2. Other***		$							
f. X-rays and Related Radiological Procedures***		$	943	943					
g. Dental (*Not dentists who should be included under salaries or fees*)		$							
h. Laboratory***		$	3,949	3,949					
i. Recreation		$							
j. Direct Management Services*		$	142,379	142,379					
k. Indirect Management Services*		$	35,277	35,277					
l. Cable TV		$							
m. Other (Specify)**** See Attached Schedule		$	86,759	86,759					
n. Physical Therapy Expense		$							
o. Speech Therapy Expense		$							
5P. ***Total Resident Care Expenditures*** (5a - 5o)		$	512,461	512,461					

* 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 in the Adjustment column.

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

Schedule of Other Resident Care

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
NURSING ADMIN SUPPLIES	$ 367				$ -	
NURSING MINOR EQUIP	$ 2,754				$ -	
MEDICAL RECORDS SUPPLIES	$ (404)				$ -	
MEDICAL RECORDS MINOR EQUIPMENT	$ -				$ -	
NON-COVERED PPS DR. VISITS	$ -				$ -	
RESIDENT CARE SUPPLIES	$ -				$ -	
CENTRAL SUPPLY MINOR EQUIPMENT	$ 10,873				$ -	
PERSONAL CARE SUPPLIES	$ 1,052				$ -	
INCONTINENCY SUPPLIES	$ -				$ -	
VACCINE RESIDENTS	$ 6,189				$ -	
PATIENT SPECIAL NEEDS	$ 1,775				$ -	
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	$ 36,599				$ -	
EQUIPMENT RENTAL: AIDS UNIT	$ -				$ -	
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	$ -				$ -	
PEN THERAPY FOOD NOT BILLABLE TO PART B	$ 5,556				$ -	
HI LOW BED RENTAL & MATTRESSES	$ -				$ -	
IV THERAPY SUPPLIES	$ 16,079				$ -	
IV THERAPY CONTRACT SERVICE	$ -				$ -	
MEDICAL WASTE CONTRACT SERVICE	$ 1,670				$ -	
ACTIVITIES SUPPLIES	$ 2,947				$ -	
ACTIVITIES MINOR EQUIPMENT	$ 1,303				$ -	
ADMISSIONS SUPPLIES	$ -				$ -	
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS						
STRIKE COSTS NON REIMBURSABLE	$ -				$ -	
COVID NON REIMBURSABLE	$ -				$ -	
Total Other Resident Care	$ 86,759	$ -	$ -	$ -	$ -	$ -

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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	9/30/2023	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)	Other	Pg	Line
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	○	⊙	VENDOR	Housekeeping Services	547,943			20	4b
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	○	⊙	VENDOR	Laundry Services	511,219			19	3b
Eagle Elevator		○	⊙	VENDOR	Elevator Contract	7,011			22	6F
Brightview Landscapes LLC		○	⊙	VENDOR	Landscaping	8,920			22	6F
Peter Marcue		○	⊙	VENDOR	Snow Removal	15,697			22	6F
CWPM LLC		○	⊙	VENDOR	Trash removal	31,416			22	6F
Facility Complaince		○	⊙	VENDOR	Plant Contract Services				22	6F
American HealthTech	P.O. Box 9001006, Louisville, KY 40290	○	⊙	VENDOR	Software Maintenance Contract	18,301			16	M11
Automatic Data Processing		○	⊙	VENDOR	Payroll Services	41,888			16	M11
National Datacare Corp		○	⊙	VENDOR	Resident Trust Software	5,040			16	M11
Prime Care Technologuy services		○	⊙	VENDOR	Computer Consulting Services	40,880			16	M11
Priotiry Express		○	⊙	VENDOR	Courier Services	3,686			16	M11
Point Right Inc		○	⊙	VENDOR	Nursing Software	5,149			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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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	9/30/2023					22	37
Item		Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	$	44,910	44,910					
b. Heat	$	64,420	64,420					
c. Light & Power	$	169,399	169,399					
d. Water	$	58,019	58,019					
e. Equipment Lease (*Provide detail on page 22b*)	$	26,806	26,806					
f. Other (*itemize*)	$	97,597	97,597					
See Attached Schedule								
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	461,150	461,150					
7. Depreciation (*complete schedule page 23**)								
a. Land Improvements	$							
b. Building & Building Improvements	$	23,260	23,260					
c. Non-Movable Equipment	$							
d. Movable Equipment	$	51,844	51,844					
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	75,104	75,104					
8. Amortization (*Complete att. Schedule Page 24**)								
a. Organization Expense	$							
b. Mortgage Expense	$							
c. Leasehold Improvements	$	52,289	52,289					
d. Other (*Specify*)	$							
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	52,289	52,289					
9. Rental payments on leased real property less real estate taxes included in item 10b	$	451,740	451,740					
10. Property Taxes								
a. Real estate taxes paid by owner	$							
b. Real estate taxes paid by lessor	$	127,198	127,198					
c. Personal property taxes	$	12,491	12,491					
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	718,821	718,821					

* 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	Adjustment	(Specify)	Adjustment	Other	Adjustment
PLANT SUPPLIES	$ 3,662				$ -	
PLANT CONTRACT SERVICE LABOR	$ 10,633				$ -	
ELEVATOR CONTRACT SERVICE	$ 7,011				$ -	
FIRE/SPRINKLER CONTRACT SERVICE	$ 6,598				$ -	
LANDSCAPING CONTRACT SERVICE	$ 8,920				$ -	
SNOW REMOVAL CONTRACT SERVICE	$ 15,697				$ -	
TRASH REMOVAL CONTRACT SERVICE	$ 31,416				$ -	
PLANT (POOL) CONTRACT SERVICES OTHER	$ -				$ -	
SECURITY CONTRACT SERVICE	$ -				$ -	
PLANT CONTRACT SERVICE OTHER	$ 4,072				$ -	
PLANT MINOR EQUIPMENT	$ 7,187				$ -	
RENT AUTO	$ -				$ -	
RENT EQUIPMENT	$ 2,400				$ -	
RENT OTHER	$ -				$ -	
Total Other Repairs and Maintenance	$ 97,597	$ -	$ -	$ -	$ -	$ -

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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
Westside Care Center, LLC	2291	9/30/2023	22b	37

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	automatic renewals	14,299	14,299
Wells Fargo C/O GE Capital C/O Ricoh USA, P.O.Box 41564, Philadelphai, PA 19101	○	⊙	Copier	11/20/14	48 months	1,024	1,024
Mail Finance/Neopost New England, 25881 Newtwork Place, Chicago, IL 60673	○	⊙	Postage Meter Rental		Monthly	11,483	11,483
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total ***** 26,806

* 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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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2023	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	192,910			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					1,277,305		1,277,305	1,103,773			50,348	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative					2,725						318	
d. Standard Resident					17,950						1,178	
e. Specialized Resident												
Total Acquired during this report period					20,675						1,496	
D-3. Subtotal												51,844
E. ***Total Depreciation***												75,104

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:						
1/24/2023	Fire Extinguishers: Allstate Fire	Standard Resident	$ 2,661	60	$ 355	
4/12/2023	Ice Maker - Direct Supply	Standard Resident	$ 3,344	120	$ 139	
5/19/2023	Mattress: Direct Supply	Standard Resident	$ 2,718	60	$ 181	
4/30/2023	Wound Vac: H&R Healthcare	Standard Resident	$ 4,669	60	$ 389	
6/7/2023	Upgrade Dishwasher: Culligan Waterco of NE	Standard Resident	$ 4,558	120	$ 114	
2/13/2023	SDWAN Equip: CMS	Administrative	$ 2,725	60	$ 318	
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
Total additions for Movable Equipment			$ 20,675		$ 1,496	*
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:					
11/29/2022	Replace Doors: Target 10 Construction	$ 16,840	120	$ 1,403	
5/3/2023	Plumbing: Advance Plumbing	$ 3,489	300	$ 47	
8/11/2023	Laundry Back Flow: Facilities Comp	$ 2,948	120	$ 25	
8/18/2023	Upgrade fire Sprinkler STM: Facilities Compliance	$ 5,591	300	$ 19	
Total additions for Leasehold Improvement		$ 28,867		$ 1,493	*
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	9/30/2023	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				856,708	512,089			50,796	
2. Disposals (attach schedule)									
3. Acquired during this report period									
(attach schedule)				28,867				1,493	
C-4. Subtotal									52,289
D. ***Total Amortization***									52,289

* 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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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	9/30/2023	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	
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 year with 2	313,780

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2023	26	37

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

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2023	27	37

Item	Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
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*) $	32,545	32,545					
INTEREST							
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	32,545	32,545					
14. Insurance							
a. Insurance on Property (buildings only) $	12,459	12,459					
b. Insurance on Automobiles $							
c. Insurance other than Property (as specified above)							
1. Umbrella (*Blanket Coverage*) $	126,046	126,046					
2. Fire and Extended Coverage $							
3. Other (*Specify*) $	17,469	17,469					
Other insurance, crime							
14d. ***Total Insurance Expenditures (14a + b + c)*** $	155,974	155,974					
15. ***Total All Expenditures (A-13 thru C-14)*** $	15,744,765	15,744,765					

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Westside Care Center, LLC	2291	9/30/2023	30 | 37

Item		Total	CCNH / RHNS	(Specify)	Other
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	12,609,613	12,609,613		
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)*	$	1,090,536	1,090,536		
b. Medicare Room and Board Contractual Allowance **	$				
4. a. Private-Pay Residents and Other	$	229,578	229,578		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	86,972	86,972		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(86,772)	(86,772)		
c. Prescription Drugs - Non-Medicare	$	45,399	45,399		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(45,399)	(45,399)		
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	$	116,423	116,423		
b. Physical Therapy - Medicare Contractual Allowance **	$	(80,587)	(80,587)		
c. Physical Therapy - Non-Medicare	$	230,897	230,897		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(230,897)	(230,897)		
4. a. Speech Therapy - Medicare	$	13,591	13,591		
b. Speech Therapy - Medicare Contractual Allowance **	$	(10,030)	(10,030)		
c. Speech Therapy - Non-Medicare	$	41,620	41,620		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(41,620)	(41,620)		
5. a. Occupational Therapy - Medicare	$	108,743	108,743		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(83,245)	(83,245)		
c. Occupational Therapy - Non-Medicare	$	212,007	212,007		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(210,198)	(210,198)		
6. a. Other *(Specify)* - Medicare	$	(264,627)	(264,627)		
b. Other *(Specify)* - Non-Medicare	$	106,556	106,556		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	13,838,561	13,838,561		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	2	2		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	30,725	30,725		
V. Total Other Revenue (1 thru 8)	$	30,728	30,728		
VI. Total All Revenue (III +V)	$	13,869,288	13,869,288		

* *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)	Other
	Lab Medicare	$ 5,010		
	Lab Medicare CA	$ (5,010)		
	Oxygen Medicare	$ -		
	Oxygen Medicare CA	$ -		
	Equipment rental	$ 468		
	Equipment rental CA	$ (468)		
	Pen Therapy	$ -		
	Pen Therapy CA	$ -		
	Therapy Beds Medicare	$ -		
	Therapy Beds Medicare CA	$ -		
	Radiology Medicare	$ 880		
	Radiology Medicare CA	$ (880)		
	IV Therapy	$ 9,019		
	IV Therapy CA	$ (9,019)		
	Medical Transportation	$ -		
	Medical Transportation CA	$ -		
	Glucose testing	$ -		
	Glucose testing CA	$ -		
	Outpatient therapy Medicare	$ -		
	MEDICAID COVID REVENUE	$ -		
	CRF MEDICAID REVENUE	$ -		
	MEDICAID WAGE & ENHANCEMENT RESERVE	$ (264,627)		
Total Other Resident Revenue - Medicare		$ (264,627)	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	Other
	Lab	619		
	Lab CA	(619)		
	Oxygen	$ -		$ -
	Oxygen CA	$ -		$ -
	Equipment rental	$ 9,800		
	Equipment rental CA	$ (9,800)		
	Pen Therapy	$ -		
	Pen Therapy CA	$ -		
	Therapy Beds	$ -		
	Therapy Beds CA	$ -		
	Radiology	$ 63		
	Radiology CA	$ (63)		
	Medical Transportation	$ -		
	Medical Transportation CA	$ -		
	Glucose Testing	$ -		
	Glucose Testing CA	$ -		
	IV therapy	$ 18,432		$ -
	IV therapy CA	$ (18,432)		$ -
	Flu shot revenue	$ 1,956		
	Outpatient therapy	$ -		
	prior period revenue	$ (23,402)		
	Optum B	$ 240,555		
	Optum B CA	$ (110,755)		
	C/A VBP	$ (1,798)		
	rounding	$ (1)		
Total Other Resident Revenue		$ 106,556	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH / RHNS	(Specify)	Other
	INTEREST INCOME		$ 2		
Total Interest Income			$ 2	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	Other
	MEALS	$ -		
	TELEVISION INCOME	$ -		
	OTHER INCOME: DMHAS OPERATING REVENUE	$ -		
	OTHER INCOME: DMHAS ORGANIZATIONAL REV	$ -		
	OTHER INCOME: DEFERRED REVENUE	$ 3,239		
	MEDICARE COVID STIMULUS REVENUE	$ -		
	CONCESSIONS / VENDING INCOME	$ 496		
	RESIDENT LATE FEE REVENUE	$ -		
	RESIDENT ATTORNEY FEE REVENUE	$ -		
	TELEPHONE INCOME	$ -		
	OTHER INCOME	$ -		
	OPTUM DIVIDENDS REVENUE	$ 26,990		
	OPTUM OUTLIERS	$ -		
	HHS GENERAL FUND REVENUE	$ -		
	HHS INFECTION CONTROL REVENUE	$ -		
	CARES ACT REVENUE	$ -		
	EMPLOYEE TESTING REVENUE	$ -		
	COVID ECHO TRAINING REVENUE	$ -		
Total Other Revenue		$ 30,725	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2291	9/30/2023	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 14,196
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 3,735,244
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 16,449
5. Prepaid Expenses				$ 141,387
a. Prepaid Insurance		102,486		
b. Prepaid Property Taxes		35,641		
c. Prepaid Expenses Other		3,260		
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ (2,877,945)
Due From (to) Related Parties		(823,281)		
Other Owners reserves		(2,054,664)		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,029,330
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost	342,818		$ 126,647
	Accum. Depreciation	216,170	Net	
4. Leasehold Improvements	*Historical Cost	885,576		$ 321,198
	Accum. Depreciation	564,378	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	1,297,980		$ 142,363
	Accum. Depreciation	1,155,618	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 13,676
Construction in Progress		13,676		
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 603,884

* 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	9/30/2023	32	37

Account				Amount
			Total Brought Forward:	$ 1,633,214
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				$ 543,484
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$ 98,427
Patient Trust Funds		81,872		
Long Term Deposit - primecare		16,555		
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 2,567,265
RIGHT TO USE ASSET		3,013,370		
ACCUM RIGHT TO USE ASSET		(446,105)		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 3,209,176
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 4,842,391

* 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	9/30/2023	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 1,472,284
	2. Notes Payable (*itemize*)				$ 758,593
	Working Capital Line of Credit		758,593		
	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*)				$ 487,209
	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*)				$ 4,457,635
	Related Party Payables	4,001,339			
	Accrued Expenses	85,585			
	Accrued Resident User Fees	226,953			
	Accrued Workers Comp Expense	143,758	See Schedule		
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 7,175,721

* 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	9/30/2023	34	37

Account				Amount
			Total Brought Forward:	7,175,721
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*)				$ 81,872
Patient Trust Funds	81,872			
See Schedule				
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ 81,872
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 7,257,593

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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	9/30/2023	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	$ (564,726)
	6. Gain or Loss for Period 10/1/2022 thru 9/30/2023	$ (1,875,477)
	7. Total Net Worth	$ (2,415,203)
C.	***Total Reserves and Net Worth***	$ (2,415,203)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 4,842,391

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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	9/30/2023	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2022			$
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 13,869,288
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 15,744,765
D.	Net Income or Deficit			$ (1,875,477)
E.	Balance			$ (1,875,477)
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***	09/30/23		$ (1,875,477)

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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	9/30/2023	37	37

Check appropriate category

☐ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined	☑ (Specify)	☑ 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