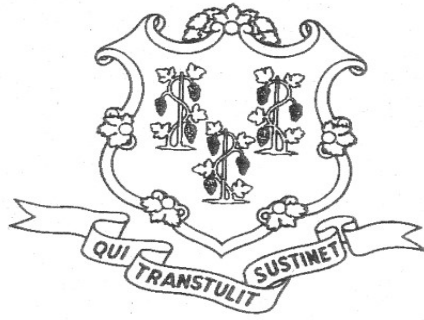


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2023

Name of Facility (as licensed) West Haven Center for Nursing & Rehabilitation LLC	
Address (No. & Street, City, State, Zip Code) 310 Terrace Avenue, West Haven, CT 06516	
Type of Facility Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <span style="margin-left: 150px;"><input type="checkbox"/> (Specify)</span> <span style="margin-left: 150px;"><input type="checkbox"/> (Specify)</span>	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

License Numbers:	CCNH / RHNS 2466	(Specify)	(Specify)	Medicare Provider 07-5201
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Medicaid Provider Numbers:	CCNH / RHNS 10926	(Specify)	(Specify)
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### General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
West Haven Center for Nursing & Rehabilitation LLC	2466	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 IMPRISONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for West Haven Center for Nursing & Rehabilitation 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) Michael Bell			Printed Name (Owner) Menajem Salamon		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

# Table of Contents

General Information - Administrator's/Owner's Certification	1
General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
General Information and Questionnaire - Type of Facility - Organization Structure	2
General Information and Questionnaire - Partners/Members	3
General Information and Questionnaire - Corporate Owners	3A
General Information and Questionnaire - Individual Proprietorship	3B
General Information and Questionnaire - Related Parties	4
General Information and Questionnaire - Basis for Allocation of Costs	5
General Information and Questionnaire - Other Lines of Business	6
General Information and Questionnaire - Other Lines of Business (Continued)	7
Schedule of Resident Statistics	8
Schedule of Resident Statistics (Cont'd)	9
A. Report of Expenditures - Salaries & Wages	10
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B. Report of Expenditures - Professional Fees	13
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C. Expenditures Other than Salaries - Administrative and General	15
C. Expenditures Other than Salaries (Cont'd) - Administrative and General	16
Schedule C-1 - Management Services	17
C. Expenditures Other than Salaries (Cont'd) - Dietary	18
C. Expenditures Other than Salaries (Cont'd) - Laundry	19
C. Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
Depreciation Schedule	23
Amortization Schedule	24
C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C. Expenditures Other than Salaries (Cont'd) - Interest	26
C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
F. Statement of Revenue	30
G. Balance Sheet	31
G. Balance Sheet (Cont'd)	32
G. Balance Sheet (Cont'd)	33
G. Balance Sheet (Cont'd)	34
G. Balance Sheet (Cont'd) - Reserves and Net Worth	35
H. Changes in Total Net Worth	36
I. Preparer's/Reviewer's Certification	37

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility West Haven Center for Nursing & Rehabilitation LLC	Period Covered:	From 10/1/2022	To 9/30/2023	
Address of Facility 310 Terrace Avenue, West Haven, CT 06516				
Report Prepared By Zella Healthcare Consulting, LLC	Phone Number 203-808-8197	Date 1/29/2024		
Item	Total	CCNH / RHNS	(Specify)	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

**General Information and Questionnaire**  
**Type of Facility - Organization Structure**

Phone No. of Facility 203-654-2100		Report for Year Ended 9/30/2023	Page 2	of 37
Name of Facility (as shown on license) West Haven Center for Nursing & Rehabilitation LLC		Address (No. & Street, City, State, Zip) 310 Terrace Avenue, West Haven, CT 06516		
License Numbers:	CCNH / RHNS 2466	(Specify)	(Specify)	Medicare Provider No. 07-5201
Type of Facility (Check appropriate box(es)) Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box) <input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No                 If "Yes," explain fully.				
<b>Administrator</b>				
Name of Administrator Michael Bell		Nursing Home Administrator's License No.:	2116	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

**General Information and Questionnaire  
 Partners/Members**

Name of Facility West Haven Center for Nursing & Rehabilitation LLC		License No. 2466	Report for Year Ended 9/30/2023	Page 3	of 37
Legal Name of Partnership/LLC West Haven Center for Nursing & Rehabilitation LLC		Business Address 310 Terrace Avenue, West Haven, CT 06516		State(s) and/or Town(s) in Which Registered Connecticut	
Name of Partners/Members	Business Address	Title		% Owned	
Alan Landa	310 Terrace Avenue, West Haven, CT 06516			38%	
Sari Landa	310 Terrace Avenue, West Haven, CT 06516			6%	
Mordejai Salamon	310 Terrace Avenue, West Haven, CT 06516			7%	
Menajem Salamon	310 Terrace Avenue, West Haven, CT 06516			44%	
Various Other Less than 5% ea				5%	

## General Information and Questionnaire Corporate Owners

Name of Facility West Haven Center for Nursing & Rehabilitation	License No. 2466	Report for Year Ended 9/30/2023	Page 3A	of 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	
N/A				
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
N/A				
Names of Stockholders Owning at Least 10% of Shares				
N/A				

### General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
West Haven Center for Nursing & Rehabilitation L	2466	9/30/2023	3B	37

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

Owner(s) of Facility

N/A



**General Information and Questionnaire  
Related Parties\***

Name of Facility West Haven Center for Nursing & Rehabilitation LLC	License No. 2466	Report for Year Ended 9/30/2023	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?     Yes       No      If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
West Haven Propco, LLC	310 Terrace Avenue, West Haven, CT 06516	<input type="radio"/>	<input checked="" type="radio"/>		Rent	Page 22 Line 9	1,200,000	975,663
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

\* Use additional sheets if necessary.  
\*\* Provide the percentage amount of revenue received from non-related parties.

## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility West Haven Center for Nursing & Rehabilitation	License No. 2466	Report for Year Ended 9/30/2023	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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.

**General Information and Questionnaire**  
**Other Lines of Business**

Name of Facility West Haven Center for Nursing & Re	License No. 2466	Report for Year Ended 9/30/2023	Page 6	of 37
Square footage of entire facility.		23,932		
<b>Outpatient Therapy</b>				
Does the Facility provide outpatient therapy services?		No		
<i>If yes, please complete the following:</i>				
Square footage of therapy space.				
<b>Meals on Wheels</b>				
Does the facility provide Meals on Wheels?		No		
<i>If yes, please complete the following:</i>				
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?			
<i>If yes, please state where costs are reported.</i>				
No	Are drivers for the program included in the facility's payroll?			
<i>If yes, please complete the following:</i>				
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				
<b>Apartments, Independent Living, Assisted Living</b>				
Does the facility have apartments, independent living, and/or assisted living?		No		
<i>If yes, please complete the following:</i>				
Square footage of apartments				
Square footage of independent living				
Square footage of assisted living				
Please identify the services provided:				

**General Information and Questionnaire  
 Other Lines of Business (Continued)**

Name of Facility	License No.	Report for Year Ended	Page	of
West Haven Center for	2466	9/30/2023	7	37

**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:

### Schedule of Resident Statistics

Name of Facility			License No.		Report for Year Ended				Page	of			
West Haven Center for Nursing & Rehabilitation LLC			2466		9/30/2023				8	37			
	Total All Levels	Total CCNH / RHNS Level	Total	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH / RHNS	(Specify)	(Specify)	Total	CCNH / RHNS	(Specify)	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	98	98			98	98							
B. On last day of THIS report period	98	98							98	98			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	84	84			84	84							
B. As of midnight of THIS report period	95	95							95	95			
3. Total Number of Days Care Provided During Period													
A. Medicare	4,474	4,474			3,772	3,772			702	702			
B. Medicaid (Conn.)	26,536	26,536			19,164	19,164			7,372	7,372			
C. Medicaid (other states)													
D. Private Pay	668	668			480	480			188	188			
E. State SSI for RCH													
F. Other (Specify) Hospice/HMO	14	14			14	14							
G. Total Care Days During Period (3A thru F)	31,692	31,692			23,430	23,430			8,262	8,262			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days	33	33							33	33			
B. Other Bed Reserve Days	5	5			5	5							
5. <b>Total Resident Days (3G + 4A + 4B)</b>	31,730	31,730			23,435	23,435			8,295	8,295			

### Schedule of Resident Statistics (Cont'd)

Name of Facility West Haven Center for Nursing & Rehabilitation L	License No. 2466	Report for Year Ended 9/30/2023	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?  Yes  No  
 If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change	
	CCNH / RHNS	(Specify)	(Specify)	Lost			Gained			CCNH / RHNS	(Specify)	(Specify)		
	(1)	(2)	(3)	(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)	(Specify)
1st change			
2nd change			
3rd change			
4th change			

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH / RHNS	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	(Specify)	R.C.H.	ICF-MR
No. of Residents	9	85		1				
Per Diem Rate								
a. One bed rm.	PDPM	302.08		380.00				
b. Two bed rms.	PDPM	302.08		380.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B	1,447	1,447			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	3,082	3,082			
2. Restorative Treatments					
C. Other	3,327	3,327			
<b>D. Total Physical Therapy Treatments</b>	<b>7,856</b>	<b>7,856</b>			

8. Total Number of Speech Therapy Treatments

	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B	580	580			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	415	415			
2. Restorative Treatments					
C. Other	617	617			
<b>D. Total Speech Therapy Treatments</b>	<b>1,612</b>	<b>1,612</b>			

9. Total Number of Occupational Therapy Treatments

	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B	2,922	2,922			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	3,347	3,347			
2. Restorative Treatments					
C. Other	4,284	4,284			
<b>D. Total Occupational Therapy Treatments</b>	<b>10,553</b>	<b>10,553</b>			

### Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of					
West Haven Center for Nursing & Rehabilitation LLC	2466	9/30/2023	10	37					
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No									
Total Cost and Hours									
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
<b>A. Salaries and Wages*</b>									
1. Operators/Owners (Complete also Sec. I of Schedule A1)									
2. Administrator(s) (Complete also Sec. III of Schedule A1)	174,464		2,084						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	284,337	(125,000)	10,040						
5. Dietary Service									
a. Head Dietitian									
b. Food Service Supervisor									
c. Dietary Workers	434,406		18,304						
6. Housekeeping Service									
a. Head Housekeeper									
b. Other Housekeeping Workers	364,934		12,979						
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance									
b. Other Maintenance Workers	87,724		3,537						
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	266,390		3,663						
b. RN									
1. Direct Care	899,295		17,406						
2. Administrative**									
c. LPN									
1. Direct Care	959,210		25,493						
2. Administrative**									
d. Aides and Attendants	1,459,139		62,283						
e. Physical Therapists	60,071		1,074						
f. Speech Therapists	75,453		1,676						
g. Occupational Therapists	118,364	(118,364)	2,590						
h. Recreation Workers	80,512		3,758						
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	151,744		3,702						
n. Marketing									
o. Other (Specify)									
See Attached Schedule									
<i>A-13. Total Salary Expenditures</i>	5,416,043	(243,364)	168,589						

\* 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)

Position	CCNH / RHNS			(Specify)			(Specify)		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
<b>Total</b>	\$ -	\$ -	-	\$ -	\$ -	-	\$ -	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH / RHNS			(Specify)			(Specify)		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
<b>Total</b>	\$ -	\$ -	-	\$ -	\$ -	-	\$ -	\$ -	-



**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	
West Haven Center for Nursing & Rehabilitation LLC			2466	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)	(Specify)							
<b>Section I - Operators/Owners</b>										
Menajem Salamon (Disallowed)	125,000			None	CEO	N/A	A4			
<b>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).</b>										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
West Haven Center for Nursing & Rehabilitation LLC				2466	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)	(Specify)							
<b>Section III - Administrators***</b>										
Byron, Helen(10/1/2022-5/12/2023)	91,912			Non Discriminatory	Administrator	1,336	A2			
Stango, Donna (5/12/2023-5/27/2023 and 9/5/2023-9/30/2023)	41,417			Non Discriminatory	Administrator	196	A2			
Kraus, Jonah (5/30/2023-9/14/2023)	41,135			Non Discriminatory	Administrator	552	A2			
<b>Section IV - Assistant Administrators</b>										

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

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

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

**B. Report of Expenditures - Professional Fees**

Name of Facility	License No.	Report for Year Ended	Page	of					
West Haven Center for Nursing & Rehabilitation LLC	2466	9/30/2023	13	37					
<b>Total Cost and Hours</b>									
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>									
1. Dietitian	61,236		1,282						
2. Dentist	4,920	(4,920)	41						
3. Pharmacist	15,250		162						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	120,362		1,832						
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	36,000		144						
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)									
9. Speech Therapist									
a. Resident Care	360		5						
b. Other									
10. Occupational Therapist									
a. Resident Care									
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	289,668		2,949						
2. Administrative***									
b. LPN									
1. Direct Care									
2. Administrative***									
c. Aides									
d. Other									
12. Other (Specify) See Attached Schedule									
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>527,796</b>	<b>(4,920)</b>	<b>6,414</b>						

\* 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.

**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
West Haven Center for Nursing & Rehabilitation LLC		2466	9/30/2023		14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
NutraCo	Dietician	<input type="radio"/>	<input checked="" type="radio"/>			
LTC Management	Dentist	<input type="radio"/>	<input checked="" type="radio"/>			
Guardian Consulting Services, Inc	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>			
Anuruddha Walaliyadda, MD	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
QRM	MDS Consultant	<input type="radio"/>	<input checked="" type="radio"/>			
Zella Staffing Solutions	RN Staffing	<input type="radio"/>	<input checked="" type="radio"/>			
Dynamic Reimbursement Services	MDS Consultant	<input type="radio"/>	<input checked="" type="radio"/>			
Innovations Healthcare	INC Nurse	<input type="radio"/>	<input checked="" type="radio"/>			
QRM	PT, OT, ST	<input type="radio"/>	<input checked="" type="radio"/>			
Grandison Management	PT	<input type="radio"/>	<input checked="" type="radio"/>			
Swallowing Diagnostics	ST	<input type="radio"/>	<input checked="" type="radio"/>			
Vanessa Brogden	MDS Consultant	<input type="radio"/>	<input checked="" type="radio"/>			
Joan Raymond Jeudi	MDS Consultant	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			

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

**C. Expenditures Other Than Salaries - Administrative and General**

Name of Facility	License No.	Report for Year Ended					Page	of
West Haven Center for Nursing & Rehabilitation	2466	9/30/2023					15	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
<b>1. Administrative and General</b>								
<b>a. Employee Health &amp; Welfare Benefits</b>								
1. Workmen's Compensation	\$ 305,931	305,931						
2. Disability Insurance	\$							
3. Unemployment Insurance	\$ 62,033	62,033						
4. Social Security (F.I.C.A.)	\$ 412,299	412,299						
5. Health Insurance	\$ 820,897	820,897						
6. Life Insurance (employees only) (not-owners and not-operators)	\$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 289,360	289,360						
8. Uniform Allowance	\$ 1,654	1,654						
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 34,496	34,496						
<b>b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*</b>	\$							
<b>c. Bad Debts*</b>	\$	115,729	(115,729)					
<b>d. Accounting and Auditing</b>	\$ 39,000	39,000						
<b>e. Legal (<i>Services should be fully described on Page 15b</i>)</b>	\$ 26,656	77,518	(50,862)					
<b>f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*</b>	\$							
<b>g. Office Supplies</b>	\$ 37,582	37,582						
<b>h. Telephone and Cellular Phones</b>								
1. Telephone & Pagers	\$ 11,177	11,177						
2. Cellular Phones	\$ 1,829	1,829						
<b>i. Appraisal (<i>Specify purpose and attach copy</i>)*</b>	\$							
<b>j. Corporation Business Taxes (<i>franchise tax</i>)</b>	\$							
<b>k. Other Taxes (<i>Not related to property - See Page 22</i>)</b>								
1. Income*	\$							
2. Other ( <i>Specify</i> ) See Attached Schedule	\$ 3,609	13,508	(9,899)					
3. Resident Day User Fee	\$ 573,343	573,343						
<b>Subtotal</b>	\$ 2,619,866	2,796,356	(176,490)					

\* 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	(Specify)	Adjustment
Small Balance Adjustments	\$ (1)					
Union Training Fund	\$ 31,397					
BONUS - DIRECT CARE	\$ 1,600					
BONUS - A&G	\$ 1,500					
<b>Total</b>	\$ 34,496	\$ -	\$ -	\$ -	\$ -	\$ -

**Schedule of Other Taxes**

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Sales Tax	\$ 3,609					
Entity Tax	\$ 9,899	\$ (9,899)				
<b>Total</b>	\$ 13,508	\$ (9,899)	\$ -	\$ -	\$ -	\$ -

**General Information and Questionnaire**  
**Accounting Basis**

Name of Facility West Haven Center for Nursing & I	License No. 2466	Report for Year Ended 9/30/2023	Page 15b	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:  
 Accrual     Cash     Modified Cash

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

**Independent Accounting Firm**

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Zella Healthcare Consulting	7 Eastview Drive, Simsbury, CT 06070
2 Burg & Weingarten CPA PC	170 Harborview North, Lawrence, NY 11559
3	
4	

Services Provided by This Firm (*describe fully*)

1 Monthly bookkeeping services	\$ 24,000
2 Tax returns	\$ 15,000
3	\$
4	\$
	Charge for Services Provided
	\$ 39,000

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

**Legal Services Information**

Name of Legal Firm or Independent Attorney	Telephone Number
1 NY RYTES	914-232-1005
2 Murtha Cullina	203-772-7700
3 Jackson Lewis	860-522-0404
4 American Arbitration Association	401-431-4832
5 Various (Disallowed)	N/A

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

1 1979 Marcus Ave., Ste 210, New Hyde Park, NY 11042
2 265 Church St., New Haven, CT 06510
3 90 State House Square, Hartford, CT 06103
4 1301 Atwood Ave, Suite 211N, Johnston, RI 02919
5 N/A

Services Provided by This Firm (*describe fully*)

1 Compliance	\$ 12,299
2 General Counsel	\$ 7,833
3 Union negotiations	\$ 6,470
4 Union grievances	\$ 55
5 Other (Disallowed)	\$ 50,862
	Charge for Services Provided
	\$ 77,518

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

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

Name of Facility	License No.	Report for Year Ended					Page	of
West Haven Center for Nursing & Rehabilitation LLC	2466	9/30/2023					16	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
<b>Subtotals Brought Forward:</b>	2,619,866	2,796,356	(176,490)					
<b>l. Travel and Entertainment</b>								
1. Resident Travel and Entertainment	\$							
2. Holiday Parties for Staff	\$ 950	950						
3. Gifts to Staff and Residents	\$ 540	3,320	(2,780)					
4. Employee Travel	\$	2,094	(2,094)					
5. Education Expenses Related to Seminars and Conventions	\$ 900	900						
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$	7,748	(7,748)					
7. Other ( <i>Specify</i> ) See Attached Schedule	\$ (0)	3,071	(3,071)					
<b>m. Other Administrative and General Expenses</b>								
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$ 15,722	17,222	(1,500)					
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$							
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	9,843	(9,843)					
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	\$ 10,212	10,212						
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 4,658	4,658						
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$							
9. Subscriptions	\$ 350	350						
10. Contributions*** See Attached Schedule	\$							
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$ 162,831	196,686	(33,855)					
12. Administrative Management Services**	\$							
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 9,950	29,974	(20,024)					
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 2,825,980	3,083,384	(257,405)					

\* 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 in the Adjustment column.



Schedule of Other Travel and Entertainment

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Employee Travel	\$ 3,071	\$ (3,071)				
<b>Total Other Travel and Entertainment</b>	<b>\$ 3,071</b>	<b>\$ (3,071)</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Promotional Advertising	\$ 9,843	\$ (9,843)				
<b>Total Other Advertising</b>	<b>\$ 9,843</b>	<b>\$ (9,843)</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
CT Association of Health Care Facilities	\$ 4,658					
<b>Total Dues</b>	<b>\$ 4,658</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
<b>Total Contributions</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Other Consulting Fees (Disallow)	\$ 6,630	\$ (6,630)				
Bank Charges (Disallow Nonroutine Charges \$1162)	\$ 4,464	\$ (1,162)				
Credit Card Fees	\$ 362	\$ (362)				
Licenses & Permits (Disallow CHOW License Fee \$1615)	\$ 3,743	\$ (1,615)				
Criminal Background	\$ 4,998					
Penalties	\$ 7,098	\$ (7,098)				
Utility Audit	\$ 2,679	\$ (2,679)				
Medical Records Income		\$ (478)				
<b>Total Other Administrative and General</b>	<b>\$ 29,974</b>	<b>\$ (20,024)</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule C-1 - Management Services\***

Name of Facility West Haven Center for Nursing & Rehabi	License No. 2466	Report for Year Ended 9/30/2023	Page of 17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
N/A			

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

**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
West Haven Center for Nursing & Rehabilitation LLC		2466	9/30/2023				18	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
<b>2. Dietary</b>								
<b>a. In-House Preparation &amp; Service</b>								
1. Raw Food	\$ 206,494	206,494						
2. Non-Food Supplies	\$ 75,343	75,343						
3. Other (Specify) _____	\$ _____							
<b>b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)</b>								
	\$ 1,747	1,747						
<b>c. Other (Specify) _____</b>								
	\$ _____							
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>		\$ 283,584	283,584					
<b>2E. Dietary Questionnaire</b>		<b>Total</b>	<b>CCNH / RHNS</b>	<b>(Specify)</b>		<b>(Specify)</b>		
<b>F. Resident Meals: Total no. of meals served per day:*</b>								
<b>G. Is cost of employee meals included in 2D?</b>		<input type="radio"/> Yes	<input checked="" type="radio"/> No					
<b>H. Did you receive revenue from employees?</b>		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.				
<b>I. Where is the revenue received reported in the Cost Report? (Page/Line Item)</b>								
<b>J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?</b>		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.				
<b>K. Is any revenue collected from these people?</b>		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.				
<b>L. Where is the revenue received reported in the Cost Report? (Page/Line Item)</b>								
<b>M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?</b>		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.				
<b>N. Is any revenue collected from employees?</b>		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.				
<b>O. Where is the revenue received reported in the Cost Report? (Page/Line Item)</b>								

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

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

Name of Facility		License No.	Report for Year Ended				Page	of
West Haven Center for Nursing & Rehabilitation LLC		2466	9/30/2023				19	37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	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. \$						
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)		\$	120,148	120,148				
c. Other (Specify)		\$						
<b>3D. Total Laundry Expenditures (3a + b + c)</b>		\$	120,148	120,148				
3E. Laundry Questionnaire								
F. Is cost of employee laundry included in 3D?		<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.				
G. Did you receive revenue from employees?		<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify amt.				
H. Where is the revenue received reported in the Cost Report?		(Page/Line Item)						
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?		<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.				
J. Did you receive revenue from these people?		<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify amt.				
K. Where is the revenue received reported in the Cost Report?		(Page/Line Item)						

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

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

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

Name of Facility		License No.	Report for Year Ended				Page	of
West Haven Center for Nursing & Rehabilitation		2466	9/30/2023				20	37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4.	Housekeeping	Sq. Ft. Serviced by Personnel						
a.	In-House Care	Amt.	\$ 37,634	37,634				
1.	Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )							
b.	Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )	Sq. Ft. Serviced by Personnel						
		Amt.	\$					
C.	Other ( <i>Specify</i> )	\$						
<b>4D.</b>	<b>Total Housekeeping Expenditures (4a + b + c)</b>	\$	37,634	37,634				
5.	Resident Care (Supplies)**							
a.	Prescription Drugs***							
1.	Own Pharmacy	\$						
2.	Purchased from Procure	\$		162,961	(162,961)			
b.	Medicine Cabinet Drugs	\$						
c.	Medical and Therapeutic Supplies	\$	147,991	147,991				
d.	Ambulance/Limousine***	\$						
e.	Oxygen							
1.	For Emergency Use	\$						
2.	Other***	\$		19,237	(19,237)			
f.	X-rays and Related Radiological Procedures***	\$		7,491	(7,491)			
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$						
h.	Laboratory***	\$		30,558	(30,558)			
i.	Recreation	\$	7,159	7,159				
j.	Direct Management Services*	\$						
k.	Indirect Management Services*	\$						
l.	Cable TV	\$	5,634	5,634				
m.	Other (Specify)**** See Attached Schedule	\$		25,895	(25,895)			
n.	Physical Therapy Expense	\$						
o.	Speech Therapy Expense	\$						
<b>5P.</b>	<b>Total Resident Care Expenditures (5a - 5o)</b>	\$	160,784	406,926	(246,142)			

\* 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.



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

Name of Facility West Haven Center for Nursing & Rehabilitation LLC			License No. 2466		Report for Year Ended 9/30/2023				Page of 21   37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH / RHNS	(Specify)	(Specify)	Pg	Line
ADM ENVIRONMENTAL GROUP, LLC.	1370 Coney Island Ave, Brooklyn, NY 11230	<input type="radio"/>	<input checked="" type="radio"/>		Waste Removal	33,595			22	5f
ASantino Consulting	42 Robin Hill Lane, Hamden, CT 06518	<input type="radio"/>	<input checked="" type="radio"/>		IT Consulting, Computer Purchases	21,879			Var	Var
CP CORRIDOR AHC LLC	PO Box 37006, Tampa, FL 33631	<input type="radio"/>	<input checked="" type="radio"/>		Contacted AR Services	94,900			16	m11
DOOR AND SECURITY SOLUTIONS, LLC	34 Burnham Ave, Unionville, CT 06085	<input type="radio"/>	<input checked="" type="radio"/>		Maintenance/Compliance Services	35,343			22	Var
FACILITIES COMPLIANCE FIRE PROTECTION	1492 Berlin Turnpike, Berlin, CT 06037	<input type="radio"/>	<input checked="" type="radio"/>		Maintenance/Compliance Services	24,275			22	Var
FACILITIES COMPLIANCE SERVICES LLC	1492 Berlin Turnpike, Berlin, CT 06037	<input type="radio"/>	<input checked="" type="radio"/>		Maintenance/Compliance Services	15,228			22	Var
Matrixcare	South, Minneapolis, MN 55480	<input type="radio"/>	<input checked="" type="radio"/>		AP/Payroll/Nursing Software	23,653			16	m11
New Goldland Purchasing	263 N Main Street, Spring Valley, NY 10977	<input type="radio"/>	<input checked="" type="radio"/>		Purchasing Software	18,000			16	m11
SCHOLAR PAINTING & RESTORATION	682 South Main Street, Seymour, CT 06483	<input type="radio"/>	<input checked="" type="radio"/>		Building Maintenance	39,956			22	Var
THE WINTERBERRY GROUP	2070 West Street, Southington, CT 06489	<input type="radio"/>	<input checked="" type="radio"/>		Landscaping Service	19,330			22	6f
Unitex Textile Rental Services	Parkway, Mt. Vernon, NY 10550	<input type="radio"/>	<input checked="" type="radio"/>		Laundry Service	100,544			19	3b
Med-Apparel Services	Parkway, Mt. Vernon, NY 10550	<input type="radio"/>	<input checked="" type="radio"/>		Laundry Service	19,604			19	3b
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

\* List all contracted services over \$10,000. Use additional sheets if necessary.

\*\* Refer to Page 4 for definition of related.

\*\*\* Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended		Page	of		
West Haven Center for Nursing & Rehabilitation	2466	9/30/2023		22	37		
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
6. Maintenance & Operation of Plant							
a. Repairs & Maintenance	\$ 47,750	47,750					
b. Heat	\$ 64,175	64,175					
c. Light & Power	\$ 81,120	81,120					
d. Water	\$ 112,666	112,666					
e. Equipment Lease ( <i>Provide detail on page 22b</i> )	\$ 4,524	4,524					
f. Other ( <i>itemize</i> )	\$ 85,866	97,316	(11,450)				
See Attached Schedule							
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$ 396,101	407,551	(11,450)				
7. Depreciation ( <i>complete schedule page 23*</i> )							
a. Land Improvements	\$						
b. Building & Building Improvements	\$						
c. Non-Movable Equipment	\$						
d. Movable Equipment	\$ 8,910	8,910					
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$ 8,910	8,910					
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )							
a. Organization Expense	\$						
b. Mortgage Expense	\$						
c. Leasehold Improvements	\$ 16,117	16,117					
d. Other ( <i>Specify</i> )	\$						
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$ 16,117	16,117					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 1,200,000	1,200,000					
10. Property Taxes							
a. Real estate taxes paid by owner	\$						
b. Real estate taxes paid by lessor	\$ 58,598	58,598					
c. Personal property taxes	\$ 8,958	8,958					
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$ 1,292,583	1,292,583					

\* 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	(Specify)	Adjustment
Contracted Building Maint.	\$ 18,434					
Waste Management	\$ 33,595					
Pest Control	\$ 6,468					
Landscaping	\$ 19,330					
Maint. Purchased Services	\$ 8,039					
CHOW Maintenance Services	\$ 11,450	\$ (11,450)				
<b>Total Other Repairs and Maintenance</b>	\$ 97,316	\$ (11,450)	\$ -	\$ -	\$ -	\$ -

### 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 West Haven Center for Nursing & Rehabilitation LLC			License No. 2466	Report for Year Ended 9/30/2023			Page 22b	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
Macquarie Equipment Capital Inc. PO Box 714862, Cincinnati, OH 45271	<input type="radio"/>	<input checked="" type="radio"/>	Copier Lease	01/28/22	Monthly	4,524	4,524	
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes <input type="radio"/> No	<b>Total ***</b>
							4,524	

\* 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.

### Depreciation Schedule

Name of Facility West Haven Center for Nursing & Rehabilitation LLC			License No. 2466		Report for Year Ended 9/30/2023			Page 23	of 37			
Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals				
<b>A. Land Improvements</b>												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal												
<b>B. Building and Building Improvements</b>												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
B-4. Subtotal												
<b>C. Non-Movable Equipment</b>												
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								
<b>D. Movable Equipment</b>												
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												
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative												
d. Standard Resident												
e. Specialized Resident												
Total Acquired during this report period												
D-3. Subtotal												
<b>E. Total Depreciation</b>												

8,910

8,910

Schedule of Land Improvements Acquired during this report period

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

\*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
<b>Additions:</b>				
<b>Total additions for Building Improvements</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
<b>Total additions for Non-Movable Equipment</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ - **

\*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	Cost	Useful Life	Depreciation
		Movable Category			
<b>Additions:</b>					
2/28/2023	New Beds and Mattresses	Standard Resident	\$ 4,346	36	\$ 579
10/1/2022	Computer Equipment	Administrative	\$ 2,951	36	\$ 984
1/31/2023	Computer Equipment	Administrative	\$ 2,220	36	\$ 555
9/30/2023	Computer Equipment	Administrative	\$ 5,390	36	\$ 150
		PICK A CATEGORY			
		PICK A CATEGORY			
<b>Total additions for Movable Equipment</b>			\$ 14,907		\$ 2,268 *
<b>Deletions:</b>					
<b>Total deletions for Movable Equipment</b>			\$ -		\$ - **

\*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
Various	Please see attached depreciation schedule	\$ 107,411	Various	\$ 3,339
<b>Total additions for Leasehold Improvement</b>		\$ 107,411		\$ 3,339 *
<b>Deletions:</b>				
Various	Please see attached depreciation schedule	\$ (8,124)	Various	\$ (542)
<b>Total deletions for Leasehold Improvement</b>		\$ (8,124)		\$ (542) **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

West Haven Center for Nursing & Rehabilitation  
 FYE 9-30-23  
 Asset Depreciation Schedule

1615000-00-20      Leasehold Improvements

<u>GL Account</u>	<u>Asset Description</u>	<u>Date in Service</u>	<u>Method</u>	<u>Useful Life</u> <u>(Months)</u>	<u>Historical Cost</u>	<u>Month in</u> <u>Fiscal Year</u>	<u>2022</u> <u>Depreciation</u>	<u>2022 Acc. Dep.</u>	<u>2023</u> <u>Depreciation</u>	<u>2023 Acc. Dep.</u>	<u>Net Book Value</u>
<i>FYE 12-31-21</i>											
LI	Coastal Mechanical Services - Shaft Bearing	11/15/2021	S/L	180	2,986.61	11	182.52	182.52	199.11	381.62	2,604.99
LI	S&S Wired - Mag Lock Install	12/1/2021	S/L	180	8,250.00	10	458.33	458.33	550.00	1,008.33	7,241.67
LI	AE Design - Design for Reno	12/15/2021	S/L	180	24,000.00	10	1,333.33	1,333.33	1,600.00	2,933.33	21,066.67
12-31-2021 Totals					<u>35,236.61</u>		<u>1,974.18</u>	<u>1,974.18</u>	<u>2,349.11</u>	<u>4,323.29</u>	<u>30,913.32</u>
<i>FYE 9-30-22</i>											
LI	ROBEAR MP, LLC, INSTALL/REPLACE TELEPHON	1/30/2022	S/L	180	8,401.02	9	420.05	420.05	560.07	980.12	7,420.90
LI	FACILITIES COMPLIANCE FIRE PROTECTION, I	2/1/2022	S/L	180	2,371.61	8	105.40	105.40	158.11	263.51	2,108.10
LI	JET WAVE CORP,	2/23/2022	S/L	180	2,699.80	8	119.99	119.99	179.99	299.98	2,399.82
LI	FACILITIES COMPLIANCE FIRE PROTECTION, S	2/21/2022	S/L	180	4,984.36	8	221.53	221.53	332.29	553.82	4,430.54
LI	FACILITIES COMPLIANCE FIRE PROTECTION, S	2/7/2022	S/L	180	6,219.08	8	276.40	276.40	414.61	691.01	5,528.07
LI	ELIAS RIGGING, LLC, WATER TANK PROJECT	3/2/2022	S/L	180	2,000.00	7	77.78	77.78	133.33	211.11	1,788.89
LI	FACILITIES COMPLIANCE FIRE PROTECTION, f	3/1/2022	S/L	180	2,902.93	7	112.89	112.89	193.53	306.42	2,596.51
LI	AE DESIGN GROUP, RENOVATION PROJECT	3/22/2022	S/L	180	10,000.00	7	388.89	388.89	666.67	1,055.56	8,944.44
LI	COASTAL MECHANICAL SERVICES, MAINTENANCE	3/10/2022	S/L	180	20,738.25	7	806.49	806.49	1,382.55	2,189.04	18,549.21
LI	DESIGN GROUP LLC, RETAINER/DESIGN	4/1/2022	S/L	180	12,000.00	6	400.00	400.00	800.00	1,200.00	10,800.00
LI	COASTAL MECHANICAL SERVICES, INSTALL OF	3/10/2022	S/L	180	4,071.99	7	158.36	158.36	271.47	429.82	3,642.17
LI	COASTAL MECHANICAL SERVICES, HOT WATER T	2/9/2022	S/L	180	7,950.78	8	353.37	353.37	530.05	883.42	7,067.36
LI	FACILITIES COMPLIANCE FIRE PROTECTION, W	5/2/2022	S/L	180	6,619.22	5	183.87	183.87	441.28	625.15	5,994.07
LI	AE DESIGN GROUP, DESIGN DEVELOPMENT	5/5/2022	S/L	180	12,000.00	5	333.33	333.33	800.00	1,133.33	10,866.67
LI	S & S WIRED SYSTEMS, LLC, MAGNETIC LOCK	5/29/2022	S/L	180	8,249.99	5	229.17	229.17	550.00	779.17	7,470.82
LI	AK. MECHANICE, INSTALL OF OUTLETS	5/17/2022	S/L	180	2,765.10	5	76.81	76.81	184.34	261.15	2,503.95
LI	COASTAL MECHANICAL SERVICES, NEW PUMP 1/	5/16/2022	S/L	180	4,727.26	5	131.31	131.31	315.15	446.46	4,280.80
LI	AE DESIGN GROUP, DESIGN	6/13/2022	S/L	180	10,000.00	4	222.22	222.22	666.67	888.89	9,111.11
LI	COASTAL MECHANICAL SERVICES, CONDENSOR F	6/1/2022	S/L	180	4,509.73	4	100.22	100.22	300.65	400.86	4,108.87
LI	AK. MECHANICE, NEW CIIRCUITS	8/11/2022	S/L	180	14,197.73	2	157.75	157.75	946.52	1,104.27	13,093.46
LI	SCHOLAR PAINTING & RESTORATION, FINAL PA	8/18/2022	S/L	180	9,039.75	2	100.44	100.44	602.65	703.09	8,336.66
LI	COASTAL MECHANICAL SERVICES, INSTALL OF	9/1/2022	S/L	180	8,124.16	1	45.13	45.13	541.61	586.74	7,537.42
9-30-22 Totals					<u>164,572.76</u>		<u>5,021.40</u>	<u>5,021.40</u>	<u>10,971.52</u>	<u>15,992.92</u>	<u>148,579.84</u>
<i>FYE 9-30-23</i>											
LI	COASTAL MECHANICAL SERVICES, INSTALL OF	9/1/2022	S/L	180	(8,124.16)	1	(45.13)	(45.13)	(541.61)	(586.74)	(7,537.42)
LI	FACILITIES COMPLIANCE FIRE PROTECTION, F	11/30/2022	S/L	180	2,788.92	11			170.43	170.43	2,618.49
LI	S & S WIRED SYSTEMS, LLC, FINAL PAYMENT	11/15/2022	S/L	180	3,435.03	10			190.84	190.84	3,244.20
LI	SCHOLAR PAINTING & RESTORATION, DEPOSIT	1/25/2023	S/L	180	11,986.71	9			599.34	599.34	11,387.37
LI	DOOR AND SECURITY SOLUTIONS, LLC, 50% DE	2/2/2023	S/L	180	11,336.40	8			503.84	503.84	10,832.56
LI	DOOR AND SECURITY SOLUTIONS, LLC, PROPOS	2/2/2023	S/L	180	11,336.40	8			503.84	503.84	10,832.56
LI	SAUCIER MECHANICAL SERVICES, BEARING ASS	4/10/2023	S/L	180	2,666.47	6			88.88	88.88	2,577.59
LI	FACILITIES COMPLIANCE FIRE PROTECTION, F	4/19/2023	S/L	180	9,039.75	6			301.33	301.33	8,738.43
LI	SCHOLAR PAINTING & RESTORATION, 2ND PAYM	6/6/2023	S/L	180	15,982.28	4			355.16	355.16	15,627.12
LI	DOOR AND SECURITY SOLUTIONS, LLC, INSTAL	6/29/2023	S/L	180	12,500.00	4			277.78	277.78	12,222.22
LI	SCHOLAR PAINTING & RESTORATION, ASPHALT	6/26/2023	S/L	180	11,986.71	4			266.37	266.37	11,720.34
LI	COASTAL MECHANICAL SERVICES, INSTALL OF	9/30/2023	S/L	180	5,556.46	1			30.87	30.87	5,525.59
LI	COASTAL MECHANICAL SERVICES, BOILER RELI	9/30/2023	S/L	180	3,229.59	1			17.94	17.94	3,211.65
LI	CLEANSLATE, NEW DISHWASHER	9/12/2023	S/L	180	5,565.94	1			30.92	30.92	5,535.02
					<u>99,286.50</u>		<u>(45.13)</u>	<u>(45.13)</u>	<u>2,795.93</u>	<u>2,750.79</u>	<u>96,535.71</u>
<b>Total FYE 9-30-23</b>					<u><b>299,095.87</b></u>		<u><b>6,950.45</b></u>	<u><b>6,950.45</b></u>	<u><b>16,116.55</b></u>	<u><b>23,067.00</b></u>	<u><b>276,028.87</b></u>

**1620000-00-20 Furniture, Fixture & Equipment**

<u>GL Account</u>	<u>Asset Description</u>	<u>Date in Service</u>	<u>Method</u>	<u>Useful Life (Months)</u>	<u>Historical Cost</u>	<u>Month in Fiscal Year</u>	<u>2022 Depreciation</u>	<u>2022 Acc. Dep.</u>	<u>2023 Depreciation</u>	<u>2023 Acc. Dep.</u>	<u>Net Book Value</u>
FYE 12-31-21											
12-31-2021 Totals					-		-	-			-
FYE 9-30-22											
FFE	REMED SERVICES, THERA TOUCH CX4 WITH CAR	1/31/2022	S/L	60	2,525.00	9	378.75	378.75	505.00	883.75	1,641.25
9-30-22 Totals					2,525.00		378.75	378.75	505.00	883.75	1,641.25
<b>Total FYE 9-30-23</b>					<b>2,525.00</b>		<b>378.75</b>	<b>378.75</b>	<b>505.00</b>	<b>883.75</b>	<b>1,641.25</b>

**1623000-00-20 Movable Equipment**

<u>GL Account</u>	<u>Asset Description</u>	<u>Date in Service</u>	<u>Method</u>	<u>Useful Life (Months)</u>	<u>Historical Cost</u>	<u>Month in Fiscal Year</u>	<u>2022 Depreciation</u>	<u>2022 Acc. Dep.</u>	<u>2023 Depreciation</u>	<u>2023 Acc. Dep.</u>	<u>Net Book Value</u>
FYE 12-31-21											
12-31-2021 Totals					-		-	-			-
FYE 9-30-22											
MOVE	TIMEPRO COMMEG SYSTEMS, INC, TIMEPRO	3/24/2022	S/L	60	4,055.70	7	473.17	473.17	811.14	1,284.31	2,771.40
9-30-22 Totals					4,055.70		473.17	473.17	811.14	1,284.31	2,771.40
FYE 9-30-23											
MOVE	NEW GOLDLAND PURCHASING (Beds and Mattresses)	2/28/2023	S/L	60	4,345.76	8			579.43	579.43	3,766.33
12-31-23 Totals					4,345.76		-	-	579.43	579.43	3,766.33
<b>Total FYE 9-30-23</b>					<b>8,401.46</b>		<b>473.17</b>	<b>473.17</b>	<b>1,390.57</b>	<b>1,863.74</b>	<b>6,537.72</b>

**1630000-00-20 Computers**

<u>GL Account</u>	<u>Asset Description</u>	<u>Date in Service</u>	<u>Method</u>	<u>Useful Life (Months)</u>	<u>Historical Cost</u>	<u>Month in Fiscal Year</u>	<u>2022 Depreciation</u>	<u>2022 Acc. Dep.</u>	<u>2023 Depreciation</u>	<u>2023 Acc. Dep.</u>	<u>Net Book Value</u>
FYE 12-31-21											
COMP	A Santino - Computer Equipment	11/24/2021	S/L	36	6,360.00	11	1,943.33	1,943.33	2,120.00	4,063.33	2,296.67
COMP	A Santino - Computer Network	11/29/2021	S/L	36	972.13	11	297.04	297.04	324.04	621.08	351.05
COMP	A Santino - Equipment	11/16/2021	S/L	36	350.00	11	106.94	106.94	116.67	223.61	126.39
COMP	A Santino - Laptops	12/1/2021	S/L	36	3,341.80	10	928.28	928.28	1,113.93	2,042.21	1,299.59
12-31-2021 Totals					11,023.93		3,275.60	3,275.60	3,674.64	6,950.24	4,073.69
FYE 9-30-22											
MOVE	ASANTINO CONSULTING, KISOK PROJECT	2/28/2022	S/L	36	3,350.00	8	744.44	744.44	1,116.67	1,861.11	1,488.89
MOVE	ASANTINO CONSULTING, KISOK PROJECT	7/29/2022	S/L	36	1,605.00	3	133.75	133.75	535.00	668.75	936.25
9-30-22 Totals					4,955.00		878.19	878.19	1,651.67	2,529.86	2,425.14
FYE 9-30-23											
COMP	ASANTINO CONSULTING, PRODUCTS	10/1/2022	S/L	36	2,951.00	12			983.67	983.67	1,967.33
COMP	COMPUTER EQUIPMENT	1/31/2023	S/L	36	2,220.00	9			555.00	555.00	1,665.00
COMP	COMPUTER EQUIPMENT	9/30/2023	S/L	36	5,390.00	1			149.72	149.72	5,240.28
9-30-23 Totals					10,561.00		-	-	1,688.39	1,688.39	8,872.61
<b>Total FYE 9-30-23</b>					<b>26,539.93</b>		<b>4,153.79</b>	<b>4,153.79</b>	<b>7,014.70</b>	<b>11,168.49</b>	<b>15,371.44</b>

**Amortization Schedule\***

Name of Facility			License No.		Report for Year Ended			Page	of
West Haven Center for Nursing & Rehabilitation LLC			2466		9/30/2023			24	37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period	Var	Var		199,809	6,996	SL	Various	13,320	
2. Disposals (attach schedule)	Var	Var		(8,124)	(45)	SL	Various	(542)	
3. Acquired during this report period (attach schedule)	Var	Var		107,411		SL	Various	3,339	
C-4. Subtotal									16,117
<b>D. Total Amortization</b>									16,117

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

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



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

Name of Facility West Haven Center for Nursing & Rel	License No. 2466	Report for Year Ended 9/30/2023	Page 25	of 37	
<b>11. Property Questionnaire</b>					
<b>Part A</b>					
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description	Total				
1. Date Land Purchased					
2. Date Structure Completed					
3. If <b>NOT</b> Original Owner, Date of Purchase	11/01/21				
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	98				
6. Square Footage	23,932				
7. Acquisition Cost					
a. Land					
b. Building					
<b>Part B - Owner and Related Parties</b>		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)	Variable				
b. Date Mortgage Obtained	11/01/21				
c. Interest Rate for the Cost Year	Variable				
d. Term of Mortgage (number of years)	30				
e. Amount of Principal Borrowed	5,096,154				
f. Principal balance outstanding as of 9/30/2023	3,844,410				
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>					
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					
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	

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

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

Name of Facility		License No.	Report for Year Ended				Page	of
West Haven Center for Nursing & Re		2466	9/30/2023				26	37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	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. <b>Total Building Interest Expense</b> (A1 - A4 + B5)		\$						

*(Carry Subtotals forward to next page)*

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

Name of Facility		License No.		Report for Year Ended				Page	of	
West Haven Center for Nursing &		2466		9/30/2023				27	37	
Item				Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	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) Working Capital Interest				\$	17,290	(17,290)				
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	17,290	(17,290)				
14. Insurance										
a. Insurance on Property (buildings only)			\$ 40,826	40,826						
b. Insurance on Automobiles				\$						
c. Insurance other than Property (as specified above)										
1. Umbrella (Blanket Coverage)			\$ 130,137	130,137						
2. Fire and Extended Coverage				\$						
3. Other (Specify)				\$						
14d. Total Insurance Expenditures (14a + b + c)				\$	170,963	170,963				
15. Total All Expenditures (A-13 thru C-14)				\$	10,983,332	11,763,902	(780,571)			

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended		Page	of
West Haven Center for Nursing & Rehabi	2466	9/30/2023		30	37
Item	Total	CCNH / RHNS	(Specify)	(Specify)	
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 7,672,443	7,672,443			
b. Medicaid Room and Board Contractual Allowance **	\$ 51,365	51,365			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 2,692,168	2,692,168			
b. Medicare Room and Board Contractual Allowance **	\$ (43,579)	(43,579)			
4. a. Private-Pay Residents and Other	\$ 747,883	747,883			
b. Private-Pay Room and Board Contractual Allowance **	\$ 1,699	1,699			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$				
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$				
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	\$ 43,574	43,574			
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$ 18,716	18,716			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ 61,226	61,226			
4. a. Speech Therapy - Medicare	\$ 31,690	31,690			
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$ 9,212	9,212			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$ 67,952	67,952			
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$ 23,375	23,375			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other ( <i>Specify</i> ) - Medicare	\$ 4,086	4,086			
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 434	434			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 11,382,245	11,382,245			
<b>IV. Other Revenue*</b>					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income ( <i>Specify</i> )	\$ 36	36			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 478	478			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 514	514			
<b>VI. Total All Revenue</b> (III +V)	\$ 11,382,758	11,382,758			

\* 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)	(Specify)
30 II6A	Medicare B- Coinsurance- Private	\$ (170)		
31 II6A	Medicare B- Coinsurance- HMO	\$ 260		
32 II6A	Medicare B- Coinsurance- Medicaid	\$ 4,952		
33 II6A	Medicare B - Contractual Adjustment	\$ (957)		
<b>Total Other Resident Revenue - Medicare</b>		\$ 4,086	\$ -	\$ -

**Schedule of Other Non-Medicare Resident Revenue**

**Related Exp**

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
30 II6B	Private Cert - Contractual Adjustment	\$ (2,822)		
30 II6B	Hospice Cert - Current Year Overpayment	\$ 3,257		
<b>Total Other Resident Revenue</b>		\$ 434	\$ -	\$ -

**Interest Income**

**Account**

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	(Specify)
30 IV5	Interest Income		\$ 36		
<b>Total Interest Income</b>			\$ 36	\$ -	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
30 IV8	Medical Records Income (Disallowed pg. 16)	\$ 478		
<b>Total Other Revenue</b>		\$ 478	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
West Haven Center for Nursing & Reha	2466	9/30/2023	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	59,400
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,123,415
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	45,617
a. Prepaid - Insurance	(18,382)			
b. Prepaid - Real Estate Taxes	63,999			
c. _____				
d. _____				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	
_____				
_____				
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	2,228,432
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
4. Leasehold Improvements	*Historical Cost <u>299,096</u>		\$	276,028
	Accum. Depreciation <u>23,068</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>37,467</u>		\$	23,551
	Accum. Depreciation <u>13,916</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	1,200
Construction in Progress	1,200			
See Schedule				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	300,778

\* 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	
<b>Total Prepaid Expenses</b>			

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

Page Ref	Line Ref	Description	
<b>Total Other Current Assets (Itemize)</b>			

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

Page Ref	Line Ref	Description	
<b>Total Other Fixed Assets (Itemize)</b>			

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
<b>Total Other Assets</b>			

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
<b>Total Notes Payable</b>			

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

Page Ref	Line Ref	Description	
33	A12	Due to Medicaid NAMI Audit	\$ 96,659
		Rounding	\$ (1)
<b>Total Other Current Liabilities (Itemize)</b>			\$ 96,658

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

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			

### G. Balance Sheet (cont'd)

Name of Facility West Haven Center for Nursing & Reha	License No. 2466	Report for Year Ended 9/30/2023	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$ 2,529,210	
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 <b>Total Leasehold or Like Properties</b> (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense			\$	
*Historical Cost _____ Accum. Depreciation _____ Net				
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care ( <i>itemize</i> )			\$	
_____				
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	
Name and Address	Amount	Loan Date		
7. Other Assets ( <i>itemize</i> )			\$	
_____				
See Schedule				
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$ 2,529,210	

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



### G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
West Haven Center for Nursing & Rehabilitat	2466	9/30/2023	33	37
Account			Amount	
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable			\$	462,468
2. Notes Payable ( <i>itemize</i> )			\$	(145,000)
LOC Payable - Key Bank				(145,000)
_____ _____ _____ See Schedule				
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )			\$	
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )			\$	817,705
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )			\$	
6. Accrued Payroll Taxes Payable			\$	89,456
7. Medicare Final Settlement Payable			\$	
8. Medicare Current Financing Payable			\$	
9. Mortgage Payable ( <i>Current Portion</i> )			\$	
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )			\$	
11. Accrued Income Taxes*			\$	
12. Other Current Liabilities ( <i>itemize</i> )			\$	1,950,346
		Resident Refunds	141,293	
Accrued Rent		1,549,663	HMO Onerpayment	1,500
Accrued Provider Tax		161,205	Due to Other	5
Political Action Fund		21	See Schedule	96,658
A-13. <b>Total Current Liabilities</b> (Lines A1 thru I2)			\$	3,174,975

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

(Carry Total forward to next page)

### G. Balance Sheet (cont'd)

Name of Facility West Haven Center for Nursing & Rehabili		License No. 2466	Report for Year Ended 9/30/2023	Page 34	of 37
Account				Amount	
Total Brought Forward:				3,174,975	
<b>Liabilities (cont'd)</b>					
B. Long-Term Liabilities					
1. Loans Payable-Equipment ( <i>itemize</i> )					
				\$	
Name of Lender		Purpose	Amount	Date Due	
2. Mortgages Payable					
				\$	
3. Loans from Owners or Related Parties ( <i>itemize</i> )					
				\$ (1,022,904)	
Name and Address of Lender		Amount	Loan Date		
Variou		(1,022,904)	Various		
4. Other Long-Term Liabilities ( <i>itemize</i> )					
				\$	
See Schedule					
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ (1,022,904)	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 2,152,071	


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

Name of Facility	License No.	Report for Year Ended	Page	of
West Haven Center for Nursing & Rel	2466	9/30/2023	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
<b>B. Net Worth</b>				
1. Owner's Capital			\$	154
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	758,129
6. Gain or Loss for Period			\$	(381,144)
	10/1/2022	thru	9/30/2023	
7. Total Net Worth			\$	377,139
<b>C. Total Reserves and Net Worth</b>			\$	377,139
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	2,529,210

### H. Changes in Total Net Worth

Name of Facility West Haven Center for Nursing & Rehabil	License No. 2466	Report for Year Ended 9/30/2023	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2022			\$	345,479
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	11,382,758
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	11,763,902
D. Net Income or Deficit			\$	(381,144)
E. Balance			\$	(35,665)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
Prior Period Adjustment				412,804
F-3. Total Additions			\$	412,804
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. <b>Balance at End of Period</b>			\$	377,139
				09/30/23

### I. Preparer's/Reviewer's Certification

Name of Facility West Haven Center for Nursing &	License No. 2466	Report for Year Ended 9/30/2023	Page 37	of 37
<i>Check appropriate category</i>				
Chronic and Convalescent Nursing <input checked="" type="checkbox"/> Home (CCNH) & RHNS Combined	<input type="checkbox"/> (Specify)	<input type="checkbox"/> (Specify)		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer 	Title President	Date Signed 2/15/24		
Printed Name of Preparer Stephen Bernier				
Address Address 7 Eastview Drive, Simsbury, CT 06070		Phone Number 203-808-8197		
Contacted Person Regarding Additional Information Needed Regarding This Report Stephen Bernier		Phone Number 203-808-8197		
Contact Email Address stephen.bernier@zellahc.com				