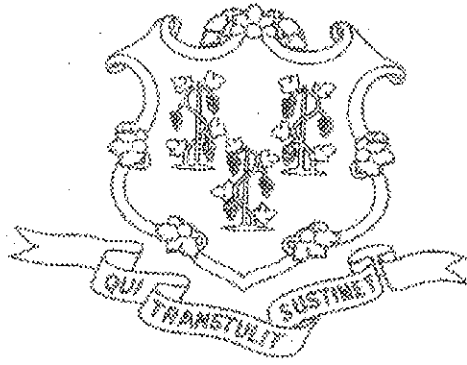


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2017

Name of Facility (as licensed) Westside Care Center, LLC	
Address (No. & Street, City, State, Zip Code) 349 Bidwell Street, Manchester, CT 06040	
Type of Facility <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input checked="" type="checkbox"/> NurseFac-Aids	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

License Numbers:	CCNH 2151-C	RHNS	NurseFac-Aids AIDS	Medicare Provider 07-5252
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Medicaid Provider Numbers:	CCNH 7807	RHNS	ICF-IID
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For Department Use Only

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

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General Information

Name of Facility (as licensed) Westside Care Center, LLC	License No. 2151-C	Report for Year Ended 9/30/2017	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Westside Care Center, LLC [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, 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) Patrick Neagle			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)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Westside Care Center, LLC	Period Covered:	From 10/1/2016	To 9/30/2017	
Address of Facility 349 Bidwell Street, Manchester, CT 06040				
Report Prepared By iCare Management LLC	Phone Number 860-570-2140	Date 2/15/2017		
Item	Total	CCNH	RHNS	NurseFac- Aids
1. Dietary wages paid \$				
2. Laundry wages paid \$				
3. Housekeeping wages paid \$				
4. Nursing wages paid \$				
5. All other wages paid \$				
6. Total Wages Paid \$				
7. Total salaries paid \$				
8. Total Wages and Salaries Paid (As per page 10 of Report) \$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-647-9191		Report for Year Ended 9/30/2017	Page 2	of 37
Name of Facility (as shown on license) Westside Care Center, LLC		Address (No. & Street, City, State, Zip) 349 Bidwell Street, Manchester, CT 06040		
License Numbers:	CCNH 2151-C	RHNS	NurseFac-Aids AIDS	Medicare Provider No. 07-5252
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input checked="" type="checkbox"/> NurseFac-Aids				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Patrick Neagle		Nursing Home Administrator's License No.:	1704	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

General Information and Questionnaire Corporate Owners

Name of Facility Westside Care Center, LLC	License No. 2151-C	Report for Year Ended 9/30/2017	Page 3A	of 37
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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			

Related Parties*

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties		Report for Year Ended 9/3/2017		Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	License No.	Page			
Westside Care Center, LLC				2151-C	4			37
Bidwell Care Center, LLC	333 Bidwell St. Manchester, CT 06040					Shared Employees	16,678	(16,678)
Chelsea Place Care Center, LLC	25 Lorraine St. Hartford, CT 06105					Shared Employees	-	-
Chestnut Point Care Center, LLC	171 Main St. East Windsor, CT 06088					Laundry Services	-	-
Chestnut Point Care Center, LLC	171 Main St. East Windsor, CT 06088					Shared Employees	8,872	(8,872)
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032					Bank Fees	-	-
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032					Shared Employees	5,145	(5,145)
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088					Laundry Services	-	-
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088					Shared Employees	-	-
Meriden Care Center, LLC (Silver Springs)	33 Roy St. Meriden, CT 06450					Shared Employees	2,736	(2,736)
Trinity Hill Care Center, LLC	151 Hillside Ave. Hartford, CT 06106					Shared Employees	13,496	(13,496)
Westside Care Center, LLC	349 Bidwell St. Manchester, CT 06040					Shared Employees	-	-
Wintonbury Care Center, LLC	140 Park Ave. Bloomfield, CT 06002					Shared Employees	4,100	(4,100)
Secure Care Center, LLC	60 West Street, Rocky Hill, CT 06087					Shared Employees	1,076	(1,076)
Touchpoints at Homecare LLC	1638 Silas Deane Hwy, Rocky Hill, CT 06067					Shared Employees	-	-
Touchpoints therapy	171 Main St. East Windsor, CT 06088					OT/PT/ST	390,949	(390,949)
Bidwell Realty, LLC	341 Bidwell St. Manchester, CT 06040					Building Lease & Rent	674,071	(674,071)
iCare Management, LLC	341 Bidwell St. Manchester, CT 06040					Postage & Legal	26,341	(26,341)
iCare Health Management, LLC	341 Bidwell St. Manchester, CT 06040					Shared EEs not part of mgmt agmt Management Services, Direct	198,506	(198,506)
						Management Services, Indirect	176,210	(176,210)
						Management Services, Administrative	23,861	(23,861)
							417,991	(417,991)
							-	-
							-	-
							-	-
							-	-
							-	-
All 9 Care Centers, mgmt co, realty cos						Share Common 401k, Pension and Insurance plans, courier, legal and various other services		

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

General Information and Questionnaire Basis for Allocation of Costs

Name of Facility Westside Care Center, LLC	License No. 2151-C	Report for Year Ended 9/30/2017	Page 5	of 37
If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:				
Item	Method of Allocation			
Dietary	Number of meals served to residents			
Laundry	Number of pounds processed			
Housekeeping	Number of square feet serviced			
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants			
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist <i>(See listing page 13)</i>			
Maintenance and operation of plant	Square feet			
Property costs (depreciation)	Square feet			
Employee health and welfare	Gross salaries			
Management services	Appropriate cost center involved			
All other General Administrative expenses	Total of Direct and Allocated Costs			
The preparer of this report must answer the following questions applicable to the cost information provided.				
1. In the preparation of this Report, were all costs allocated as required? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.				
2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.				
3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)				
<input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.				

**General Information and Questionnaire
 Leases (Excluding Real Property)**

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

Name of Facility		License No.		Report for Year Ended		Page	of	
Westside Care Center, LLC		2151-C		9/30/2017		6	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						
Accelerated Care Plus Corp. 4850 Joulé Street, Suite A-1 Reno, ADP, Inc., One ADP Drive MS-100, Augusta, GA. 30909	<input type="radio"/>	<input checked="" type="radio"/>	Omnistim Electrotherapy and Omnisound Therapeutic Ultrasound Equipment Time Clocks and Payroll Punch Equip	05/18/10	1 yr with automatic	7,634	7,634	
Wells Fargo C/O GE Capital C/O Ricoh USA, P.O.Box 41564, Philadelphia, PA 19101	<input type="radio"/>	<input checked="" type="radio"/>	Copier	06/01/10	60 Months	13,615	13,615	
Wells Fargo C/O GE Capital C/O Ricoh USA, P.O.Box 41564, Philadelphia, PA 19101	<input type="radio"/>	<input checked="" type="radio"/>	Copier	07/10/12	48 months (Lease Ended)	6,686	6,686	
Mail Finance/Neopost New England, 25881 Newtwork Place, Chicago, IL 60673	<input type="radio"/>	<input checked="" type="radio"/>	Postage Meter Rental	11/20/14	48 months	6,717	6,717	
	<input type="radio"/>	<input type="radio"/>			Monthly	618	618	
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?						<input type="radio"/> Yes	<input type="radio"/> No	Total ***
								35,270

* 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.

General Information and Questionnaire
Accounting Basis

Name of Facility Westside Care Center, LLC	License No. 2151-C	Report for Year Ended 9/30/2017	Page 7	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 1 O'Connor, Davies LLP 2 3 4	Address (No. & Street, City, State, Zip Code) 100 Great Meadow Road, Ste 401, Wethersfield, CT 06109
--	---

Services Provided by This Firm (<i>describe fully</i>)	
1 Taxes, financial statements, accounting support	\$ 4,303
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 4,303

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 1 iCare Health Management, LLC 2 Starble and Harris 3 Durant Nichols / Robinson & Cole, LLP 4 Various others (American Arbitration, Various Arbitration, Murtha Cullina, Jackson Lewis) 5 Starble and Harris, iCare Health Management LLC	Telephone Number 860-570-2140 860-678-7775 860-275-8200 860-678-7775 & 860-570-2140
---	---

Address (<i>No. & Street, City, State, Zip Code</i>)	
1 341 Bidwell Street, Manchester CT	
2 32 Main Street, Avon, CT	
3 280 Trumbull St, Hartford, CT	
4	
5 32 Main Street, Avon, CT & 341 Bidwell Street, Manchester CT	

Services Provided by This Firm (<i>describe fully</i>)	
1 Lease and contract issues, general legal advice, Labor Law	\$ 22,556
2 Lease and contract issues, general legal advice, union funds advice	\$ 3,666
3 Employment law, arbitrations, contract negotiations	\$ 4,064
4 Employment Arbitrations, healthcare law	\$ 7,020
5 Conservatorships	\$ 2,134
	Charge for Services Provided
	\$ 39,440

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

Schedule of Resident Statistics

Name of Facility Westside Care Center, LLC	License No. 2151-C	Report for Year Ended 9/30/2017						Page 8	of 37		
		Period 10/1 Thru 6/30		Period 7/1 Thru 9/30		NurseFac- Aids	RHNS			CCNH	Total
		Total CCNH Level	Total RHNS Level	Total NurseFac- Aids	Total						
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	155	155		155				157			
B. As of midnight of THIS report period	155	155		157				155			
3. Total Number of Days Care Provided During Period											
A. Medicare	2,247	2,247		1,741	1,741			506			
B. Medicaid (Conn.)	51,524	51,524		38,278	38,278			13,246			
C. Medicaid (other states)											
D. Private Pay	1,194	1,194		917	917			277			
E. State SSI for RCH											
F. Other (Specify) Insurance	230	230		179	179			51			
G. Total Care Days During Period (3A thru F)	55,195	55,195		41,115	41,115			14,080			
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)	55,195	55,195		41,115	41,115			14,080			

Schedule of Resident Statistics (Cont'd)

Name of Facility Westside Care Center, LLC			License No. 2151-C			Report for Year Ended 9/30/2017			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	NurseFac-Aids	Lost			Gained			CCNH	RHNS	NurseFac-Aids	
	(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	NurseFac-Aids		
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	NurseFac-Aids	R.C.H.	ICF-MR				
No. of Residents	7		144		4								
Per Diem Rate													
a. One bed rm.													
b. Two bed rms.	499.00		242.64		434.00								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	NurseFac-Aids	
A. Medicare - Part B									2,251	2,251			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									2,243	2,243			
C. Other									2,597	2,597			
D. Total Physical Therapy Treatments									7,091	7,091			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									340	340			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									286	286			
C. Other									295	295			
D. Total Speech Therapy Treatments									921	921			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									3,558	3,558			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									3,421	3,421			
C. Other									3,255	3,255			
D. Total Occupational Therapy Treatments									10,234	10,234			

Report of Expenditures - Salaries & Wages

Name of Facility Westside Care Center, LLC	License No. 2151-C	Report for Year Ended 9/30/2017	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RIINS	Hours	NurseFac-Aids	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)	141,798	2,150				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	202,389	9,151				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	64,770	2,063				
c. Dietary Workers	494,326	28,140				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	44,827	1,638				
b. Other Maintenance Workers	51,160	2,935				
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	233,086	4,487				
b. RN						
1. Direct Care	357,630	7,692				
2. Administrative**	235,514	5,852				
c. LPN						
1. Direct Care	1,527,439	50,661				
2. Administrative**						
d. Aides and Attendants	2,560,362	136,391				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	170,917	8,828				
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	151,576	5,016				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	57,813	2,848				
A-13. Total Salary Expenditures	6,293,608	267,851				

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

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH		RHNS		NurseFac-Aids	
	\$	Hours	\$	Hours	\$	Hours
UNIT SECRETARIES SALARIES	\$ -	-			\$ -	-
MEDICAL RECORDS SALARIES	\$ 43,162	2,089			\$ -	-
CENTRAL SUPPLY SALARIES	\$ 14,651	759			\$ -	-
RESPIRATORY THERAPY SALARIES	\$ -	-			\$ -	-
Total	\$ 57,813	2,848	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		NurseFac-Aids	
	\$	Hours	\$	Hours	\$	Hours
MEDICAL RECORDS CONTRACT SERVICE	\$ (25,785)	(1,037)			\$ -	-
ADMISSIONS C/S LABOR	\$ 51,453	1,147			\$ -	-
CENTRAL SUPPLY CONTRACT SERVICE	\$ 13,241	397			\$ -	-
ADMINISTRATIVE CONTRACT SERVICE LABOR	\$ 163,158	4,889			\$ -	-
RESPIRATORY THERAPY CONTRACT SERVICES	\$ -	-			\$ -	-
PHYSICAL THERAPY C/S MEDICIAD	\$ 49,032	643				
SPEECH THERAPY C/S Medicaid	\$ 11,966	122				
OCCUPATIONAL THERAPY C/S MEDICIAD	\$ 69,286	909				
Total	\$ 332,351	7,070	\$ -	-	\$ -	-

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

Name of Facility	License No.	Report for Year Ended		Name and Address of All Other Employment**	Total Hours Worked	Line Where Claimed on Page 10	Total Hours Worked	Page	of
		9/30/2017	11						
Name	CCNH	Salary Paid		Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Total Hours Worked	Total Hours Worked	Compensation Received
		RHNS	NurseFac-Aids						
Westside Care Center, LLC	2151-C								
Section I - Operators/Owners									
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).									

* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.
 ** Include all employment worked during the cost year.

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

Name of Facility (as licensed) Westside Care Center, LLC		License No. 2151-C		Report for Year Ended 9/30/2017		Page 12	of 37			
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Nurse/Fac- Aids							
Section III - Administrators***										
Patrick Neagle	81,510			same as employees less union funds	Administrator	1,346	A2			
David Sones	60,289			same as employees less union funds	Administrator	804	A2			
Section IV - Assistant Administrators				same as employees less union funds	Administrator		A2			

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Westside Care Center, LLC	2151-C	9/30/2017	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	NurseFac-Aids	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	630	14				
2. Dentist						
3. Pharmacist	16,866	234				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	100,364	1,292				
b. Other						
6. Social Worker	2,195					
7. Recreation Worker	17,696	35+Cable				
8. Physicians						
a. Medical Director (entire facility)	33,700	316				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify) Physician Care Contract Services	8,435	72				
9. Speech Therapist						
a. Resident Care	23,628	329				
b. Other						
10. Occupational Therapist						
a. Resident Care	137,196	1,818				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	105,296	1,650				
2. Administrative***	3,686	95				
b. LPN						
1. Direct Care	18,201	457				
2. Administrative***						
c. Aides	1,909	95				
d. Other						
12. Other (Specify) See Attached Schedule	332,351	7,070				
B-13 Total Fees Paid in Lieu of Salaries	802,153	13,441				

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

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

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

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

Name of Facility Westside Care Center, LLC		License No. 2151-C		Report for Year Ended 9/30/2017	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Omnicare	Pharmacy Consulting	<input type="radio"/>	<input checked="" type="radio"/>			
Toculpoints Therapy	Therapy	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver	Shared Employees	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Healthdrive Physician Services	Audiology, Dental and Podiatry	<input type="radio"/>	<input checked="" type="radio"/>			
IPC Hospitalists	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
Sterling Physician	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
Ready Nurse, Nurse Network	Nursing pool (RN, LPN, CNA)	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Westside Care Center, LLC	2151-C	9/30/2017		15	37
Item	Total	CCNH	RHNS	NurseFac-Aids	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 168,066	168,066			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$				
4. Social Security (F.I.C.A.)	\$ 525,503	525,503			
5. Health Insurance	\$ 1,103,320	1,103,320			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 374,050	374,050			
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>) See Attached Schedule	\$ 46,928	46,928			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 148,948	148,948			
d. Accounting and Auditing	\$ 4,303	4,303			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 39,440	39,440			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 26,936	26,936			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 25,534	25,534			
2. Cellular Phones	\$ 249	249			
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$				
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (<i>Specify</i>) See Attached Schedule	\$ 10,056	10,056			
3. Resident Day User Fee	\$ 1,160,598	1,160,598			
Subtotal	\$ 3,633,931	3,633,931			

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

(Carry Subtotals forward to next page)

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

Westside Care Center, LLC
9/30/2017

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	NurseFac-Aids
UNION TRAINING	\$ 46,928		\$ -
Total	\$ 46,928	\$ -	\$ -

Schedule of Other Taxes

Description	CCNH	RHNS	NurseFac-Aids
INTERNET EXPENSES	\$ 10,056		\$ -
Total	\$ 10,056	\$ -	\$ -

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	2151-C	9/30/2017		16	37
Item	Total	CCNH	RHNS	NurseFac-Aids	
Subtotals Brought Forward:	3,633,931	3,633,931			
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 860	860			
3. Gifts to Staff and Residents	\$ 1,417	1,417			
4. Employee Travel	\$ 166	166			
5. Education Expenses Related to Seminars and Conventions	\$ 3,577	3,577			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$ 310	310			
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 5,865	5,865			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 12,761	12,761			
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	\$ 4,153	4,153			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 11,343	11,343			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$ 250	250			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 120,625	120,625			
12. Administrative Management Services**	\$ 417,991	417,991			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 26,780	26,780			
C-14 Total Administrative & General Expenditures	\$ 4,240,030	4,240,030			

* Do not include Subscriptions, which should go in item 9.

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	NurseFac-Aids
MEALS	\$ 310		\$ -
Total Other Travel and Entertainment	\$ 310	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	NurseFac-Aids
COMMUNICATIONS-SPECIAL EVENTS	\$ 12,761		\$ -
Total Other Advertising	\$ 12,761	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	NurseFac-Aids
AETCFM			
CAHCF Dues	\$ 11,183		\$ -
OTHER DUES	\$ 160		\$ -
Total Dues	\$ 11,343	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	NurseFac-Aids
CONTRIBUTIONS	\$ 250		\$ -
Total Contributions	\$ 250	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	NurseFac-Aids
SOCIAL SERVICE SUPPLIES	\$ -		\$ -
SOC SVC MINOR EQUIPMENT	\$ -		\$ -
ADMINISTRATIVE MINOR EQUIPMENT	\$ 753		\$ -
EMPLOYEE RELATIONS	\$ 7,572		\$ -
EMPLOYEE RELATIONS-OTHER	\$ 381		\$ -
PERMITS & LICENSES	\$ 2,796		\$ -
VOLUNTEER EXPENSE	\$ -		\$ -
BANK FEES	\$ 11,900		\$ -
CMS REVISIT USER FEES	\$ -		\$ -
PENALTIES	\$ 1,740		\$ -
LATE FEES	\$ 1,639		\$ -
Rounding	\$ (1)		\$ -
Total Other Administrative and General	\$ 26,780	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Westside Care Center, LLC	2151-C	9/30/2017	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	417,991	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	176,210	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	23,861	MANAGEMENT FEES- INDIRECT CARE	Pg 20 j

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

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

Name of Facility Westside Care Center, LLC		License No. 2151-C	Report for Year Ended 9/30/2017	Page 18	of 37
Item		Total	CCNH	RHNS	NurseFac-Aids
2. Dictary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 320,467	320,467		
2.	Non-Food Supplies	\$ 31,937	31,937		
3.	Other (Specify) _____ DIETARY SUPPLEMENTS	\$ 25,227	25,227		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$ 43,469	43,469		
c. Management Services**		\$			
d. Other (Specify) _____ DIETARY MINOR EQUIPMENT		\$ 9,306	9,306		
2E. Total Dictary Expenditures (2a + b + c + d)		\$ 430,406	430,406		
2F. Dictary Questionnaire		Total	CCNH	RHNS	NurseFac-Aids
G. Resident Meals: Total no. of meals served per day:*		454	454		
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No					
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)					

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

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

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

Name of Facility Westside Care Center, LLC		License No. 2151-C	Report for Year Ended 9/30/2017	Page 19	of 37
Item		Total	CCNH	RHNS	NurseFac-Aids
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. \$	253	253		
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. \$				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. \$				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. \$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$	440,882	440,882		
c. Management Services**	\$				
d. Other (Specify) LAUNDRY MINOR EQUIPMENT	\$	308	308		
3E. Total Laundry Expenditures (3a + b + c + d)	\$	441,442	441,442		
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
H. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
I. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
L. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4. All allocations should add to total recorded in 3E.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
 *** Pounds of Laundry only required for multi-level facilities.

**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		2151-C	9/30/2017		20	37
Item			Total	CCNH	RHNS	NurseFac-Aids
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
	a. In-House Care					
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	30,900	30,900		
	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. \$	480,860	480,860		
	c. Management Services*		\$			
	d. Other (<i>Specify</i>)		\$			
	HOUSEKEEPING MINOR EQUIPMENT					
4E.	Total Housekeeping Expenditures (4a + b + c + d)		\$ 511,760	511,760		
5.	Resident Care (Supplies)**					
	a. Prescription Drugs***					
	1. Own Pharmacy		\$			
	2. Purchased from OMNICARE PHARMACY		\$ 62,454	62,454		
	b. Medicine Cabinet Drugs		\$ 25,078	25,078		
	c. Medical and Therapeutic Supplies		\$ 66,601	66,601		
	d. Ambulance/Limousine***		\$ 3,151	3,151		
	e. Oxygen					
	1. For Emergency Use		\$ 2,879	2,879		
	2. Other***		\$			
	f. X-rays and Related Radiological Procedures***		\$ 3,590	3,590		
	g. Dental (<i>Not dentists who should be included under salaries or fees</i>)		\$			
	h. Laboratory***		\$ 9,300	9,300		
	i. Recreation		\$			
	j. Other (Specify)**** See Attached Schedule		\$ 343,880	343,880		
5K.	Total Resident Care Expenditures (5a - 5j)		\$ 516,933	516,933		

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

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

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

Schedule of Other Resident Care

Description	CCNH	RHNS	NurseFac-Aids
NURSING ADMIN SUPPLIES	\$ 14		\$ -
NURSING MINOR EQUIP	\$ 9,254		\$ -
MEDICAL RECORDS SUPPLIES	\$ -		\$ -
MEDICAL RECORDS MINOR EQUIPMENT	\$ -		\$ -
MANAGEMENT ALLOCATIONS - DIRECT	\$ 176,210		\$ -
NON-COVERED PPS DR. VISITS	\$ (645)		\$ -
RESIDENT CARE SUPPLIES	\$ -		\$ -
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 8,642		\$ -
PERSONAL CARE SUPPLIES	\$ 10,780		\$ -
INCONTINENCY SUPPLIES	\$ 25,196		\$ -
VACCINE RESIDENTS	\$ 1,923		\$ -
PATIENT SPECIAL NEEDS	\$ 700		\$ -
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	\$ 28,458		\$ -
EQUIPMENT RENTAL: AIDS UNIT	\$ -		\$ -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ 274		\$ -
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ -		\$ -
HI-LOW BED RENTAL & MATTRESSES	\$ -		\$ -
IV THERAPY SUPPLIES	\$ 49,991		\$ -
IV THERAPY CONTRACT SERVICE	\$ -		\$ -
MEDICAL WASTE CONTRACT SERVICE	\$ 1,414		\$ -
ACTIVITIES SUPPLIES	\$ 7,807		\$ -
ACTIVITIES MINOR EQUIPMENT	\$ -		\$ -
MANAGEMENT ALLOCATION - INDIRECT	\$ 23,861		\$ -
ADMISSIONS SUPPLIES	\$ -		\$ -
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$ -		\$ -
STRIKE COSTS NON REIMBURSABLE	\$ -		\$ -
Total Other Resident Care	\$ 343,880	\$ -	\$ -

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

Name of Facility Westside Care Center, LLC		License No. 2151-C	Report for Year Ended 9/30/2017	Total Cost/Page Ref.***			Page of 21 37			
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	NurseFac-Aids	Pg	Line
		Yes	No							
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	O	O	VENDOR	Housekeeping Services	502,703			20	4b
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	O	O	VENDOR	Laundry Services	441,367			19	3b
Eagle Elevator		O	O	VENDOR	Elevator Contract	6,094			22	6F
Bioserve, Inc.		O	O	VENDOR	Medical Waste	1,414			22	6F
Brightview Landscapes/Primary Landscaping		O	O	VENDOR	Snow Removal/Landscaping	14,703			22	6F
CWPM		O	O	VENDOR	Trash removal	26,353			22	6F
American HealthTech		O	O	VENDOR	Software Maintenance Contract	10,894			16	M11
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	O	O	VENDOR	Payroll Services	53,206			16	M11
National Datacare Corp		O	O	VENDOR	Resident Trust Software	3,799			16	M11
Prime Care Technology services		O	O	VENDOR	Computer Consulting Services	22,108			16	M11
Priority Express		O	O	VENDOR	Courier Services	5,585			16	M11
Point Right Inc		O	O	VENDOR	Nursing Software	4,680			16	M11
		O	O	VENDOR					18	2b
		O	O	VENDOR					22a	

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

** Refer to Page 4 for definition of related.

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
Westside Care Center, LLC	2151-C	9/30/2017			22	37
Item	Total	CCNH	RHNS	NurseFac-Aids		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 43,100	43,100				
b. Heat	\$ 39,530	39,530				
c. Light & Power	\$ 149,149	149,149				
d. Water	\$ 60,625	60,625				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 35,270	35,270				
f. Other (<i>itemize</i>)	\$ 93,598	93,598				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 421,272	421,272				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$ 27,228	27,228				
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 51,485	51,485				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 78,713	78,713				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 33,743	33,743				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 33,743	33,743				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 559,447	559,447				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 123,206	123,206				
c. Personal property taxes	\$ 10,132	10,132				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 805,240	805,240				

* 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	NurseFac-Aids
PLANT SUPPLIES	\$ 14,244		\$ -
PLANT CONTRACT SERVICE LABOR	\$ 3,566		\$ -
ELEVATOR CONTRACT SERVICE	\$ 6,094		\$ -
FIRE/SPRINKLER CONTRACT SERVICE	\$ 6,373		\$ -
LANDSCAPING CONTRACT SERVICE	\$ 8,530		\$ -
SNOW REMOVAL CONTRACT SERVICE	\$ 6,172		\$ -
TRASH REMOVAL CONTRACT SERVICE	\$ 26,353		\$ -
HVAC CONTRACT SERVICE	\$ -		\$ -
SECURITY CONTRACT SERVICE	\$ -		\$ -
PLANT CONTRACT SERVICE OTHER	\$ 10,938		\$ -
PLANT MINOR EQUIPMENT	\$ 11,329		\$ -
RENT AUTO	\$ -		\$ -
RENT EQUIPMENT	\$ -		\$ -
RENT OTHER	\$ -		\$ -
Total Other Repairs and Maintenance	\$ 93,598	\$ -	\$ -

Depreciation Schedule

Name of Facility Westside Care Center, LLC		License No. 2151-C		Report for Year Ended 9/30/2017				Page 23	of 37			
		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals			
A. Land Improvements												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal												
B. Building and Building Improvements												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
B-4. Subtotal												
C. Non-Movable Equipment												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
C-4. Subtotal												
Is a mileage logbook maintained?	Yes	No	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
			Month	Year								
D. Movable Equipment												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. Van Repair: Hillside Automotive Cel x												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period												
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)												
D-3. Subtotal												
E. Total Depreciation												
											51,485	
											78,713	

Westside Care Center, LLC
9/30/2017

Schedule of Land Improvements Acquired during this report period

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

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

Schedule of Building Improvements Acquired during this report period

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

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

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Non-Movable Equipment		\$ -		\$ - *
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ - **

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

Amortization Schedule*

Name of Facility Westside Care Center, LLC	Date of Acquisition		License No. 2151-C	Report for Year Ended 9/30/2017			Page 24	of 37
	Month	Year		Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %		
Item			Length of Amortization	Cost to Be Amortized			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				453,063	242,336		33,274	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)				14,712			469	
C-4. Subtotal								33,743
D. Total Amortization								33,743

* Straight-line method must be used.
 ** Specify which of the following bases were used:
 A. Minimum of 5 years or 60 months.
 B. Life of mortgage; OR
 C. Remaining Life of Lease; OR
 D. Actual Life if owned by Related Party.

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

Name of Facility Westside Care Center, LLC	License No. 2151-C	Report for Year Ended 9/30/2017	Page 25	of 37
11. Property Questionnaire				
Part A				
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	04/01/1999			
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	162			
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building				
Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	fixed HUD			
b. Date Mortgage Obtained	05/30/13			
c. Interest Rate for the Cost Year	3.19%			
d. Term of Mortgage (number of years)	24			
e. Amount of Principal Borrowed	3,519,700			
f. Principal balance outstanding as of 9/30/2017				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)	Sale of Real Estate			
h. Date of Refinancing	08/09/17			
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
Part C - Arms-Length Leases for Real Property Improvements Only				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
Summit Westside SNF, LLC	349 Bidwell Street, Manchester, CT	08/09/17	15 years with 2-5 year extension	\$297,000 yr 1

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

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

Name of Facility Westside Care Center, LLC		License No. 2151-C	Report for Year Ended 9/30/2017	Page 26	of 37	
Item			Total	CCNH	RHNS	NurseFac-Aids
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Westside Care Center, LLC		2151-C		9/30/2017		27	37
Item				Total	CCNH	RHNS	NurseFac-Aids
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)				\$	90,954	90,954	
INTEREST							
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	90,954	90,954	
14. Insurance							
a. Insurance on Property (buildings only)				\$	9,047	9,047	
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$	71,001	71,001	
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$	4,238	4,238	
Other insurance, crime							
14d. Total Insurance Expenditures (14a + b + c)				\$	84,286	84,286	
15. Total All Expenditures (A-13 thru C-14)				\$	14,638,083	14,638,083	

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Westside Care Center, LLC			2151-C	9/30/2017	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	NurseFac-Aids
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$ 148,948	148,948		
10.			Accounting & Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.			Unallowable Advertising *	\$ 12,761	12,761		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 49,333	49,333		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$			
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 211,043	211,043		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
16a		PENALTIES	\$ 1,740		\$ -
16a		LATE FEES	\$ 1,639		\$ -
16a		PRIOR PERIOD EXPENSES			
		rounding	\$ (1)		
		Provider User Fee for Medicare days	\$ 45,955		\$ -
Total Other A&G Adjustments			\$ 49,333	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Westside Care Center, LLC			2151-C	9/30/2017	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	NurseFac-Aids
Subtotals Brought Forward				\$ 211,043	211,043		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$			
28.			Ambulance/Limousine	\$ 3,151	3,151		
29.			X-rays, etc	\$ 3,590	3,590		
30.			Laboratory	\$ 9,300	9,300		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ (645)	(645)		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$			
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51. Total Amount of Decrease (Items 1 - 50)				\$ 226,438	226,438		

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

Westside Care Center, LLC
9/30/2017

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
20	5J		(644.69)		-
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)	-		
13	B9A	ST- Resident Care (for outpatient therapy - see schedule)	-		
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)	-		
Total Other Ancillary Costs			\$ (645)	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
Total Excess Movable Equipment Depreciation			\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

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

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

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
Total Unallowable Building Interest			\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Westside Care Center, LLC	2151-C	9/30/2017			30	37
Item	Total	CCNH	RHNS	NurseFac-Aids		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (CT only)	\$ 12,514,668	12,514,668				
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)	\$ 912,495	912,495				
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$ 610,684	610,684				
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 58,055	58,055				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (58,055)	(58,055)				
c. Prescription Drugs - Non-Medicare	\$ 14,417	14,417				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (14,417)	(14,417)				
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	\$ 160,776	160,776				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (84,405)	(84,405)				
c. Physical Therapy - Non-Medicare	\$ 84,486	84,486				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (84,486)	(84,486)				
4. a. Speech Therapy - Medicare	\$ 57,890	57,890				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (28,005)	(28,005)				
c. Speech Therapy - Non-Medicare	\$ 22,532	22,532				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (22,532)	(22,532)				
5. a. Occupational Therapy - Medicare	\$ 244,201	244,201				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (116,340)	(116,340)				
c. Occupational Therapy - Non-Medicare	\$ 132,493	132,493				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (104,892)	(104,892)				
6. a. Other (Specify) - Medicare	\$					
b. Other (Specify) - Non-Medicare	\$ (6,280)	(6,280)				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 14,293,285	14,293,285				
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (Specify)	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (Specify)	\$ 28,070	28,070				
V. Total Other Revenue (1 thru 8)	\$ 28,070	28,070				
VI. Total All Revenue (III + V)	\$ 14,321,355	14,321,355				

* 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	NurseFac-Aids
	Lab Medicare	\$ 22,190		
	Lab Medicare CA	\$ (22,190)		
	Oxygen Medicare	\$ 71		
	Oxygen Medicare CA	\$ (71)		
	Equipment rental	\$ 254		
	Equipment rental CA	\$ (254)		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds Medicare	\$ -		
	Therapy Beds Medicare CA	\$ -		
	Radiology Medicare	\$ 574		
	Radiology Medicare CA	\$ (574)		
	IV Therapy	\$ 6,101		
	IV Therapy CA	\$ (6,101)		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose testing	\$ -		
	Glucose testing CA	\$ -		
	Outpatient therapy Medicare	\$ -		
	Total Other Resident Revenue - Medicare	\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	NurseFac-Aids
	Lab	1,595.30		
	Lab CA	(1,595.30)		
	Oxygen	\$ 174		\$ -
	Oxygen CA	\$ (174)		\$ -
	Equipment rental	\$ 6,458		
	Equipment rental CA	\$ (6,458)		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds	\$ -		
	Therapy Beds CA	\$ -		
	Radiology	\$ 350		
	Radiology CA	\$ (350)		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose Testing	\$ -		
	Glucose Testing CA	\$ -		
	IV therapy	\$ 51,811		\$ -
	IV therapy CA	\$ (51,811)		\$ -
	Flu shot revenue	\$ 8,278		
	Outpatient therapy	\$ -		
	prior period revenue	\$ (14,558)		
	rounding	\$ -		
	Total Other Resident Revenue	\$ (6,280)	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	NurseFac-Aids
	INTEREST INCOME		\$ -		
	Total Interest Income		\$ -	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	NurseFac-Aids
	MEALS	\$ -		
	TELEVISION INCOME	\$ -		
	CONCESSIONS / VENDING INCOME	\$ 2,875		
	RESIDENT LATE FEE REVENUE	\$ -		
	RESIDENT ATTORNEY FEE REVENUE	\$ -		
	TELEPHONE INCOME	\$ -		
	OTHER INCOME	\$ 655		
	OPTUM DIVIDENDS REVENUE	\$ 24,540		
	Total Other Revenue	\$ 28,070	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2151-C	9/30/2017	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	(249,898)
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,334,793
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	616,931
a. Prepaid Insurance	583,623			
b. Prepaid Property Taxes	32,906			
c. Prepaid Expenses Other	402			
d.				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	(853,444)
Due From (to) Related Parties	(268,037)			
Other Owners reserves	(585,407)			
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,848,383
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost <u>342,818</u>		\$	277,962
	Accum. Depreciation <u>64,856</u>	Net		
4. Leasehold Improvements	*Historical Cost <u>467,775</u>		\$	191,696
	Accum. Depreciation <u>276,079</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>1,040,428</u>		\$	176,238
	Accum. Depreciation <u>864,190</u>	Net		
7. Motor Vehicles	*Historical Cost <u>2,306</u>		\$	
	Accum. Depreciation <u>2,306</u>	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
Construction in Progress				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	645,896

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2151-C	9/30/2017	32	37
Account			Amount	
Total Brought Forward:			\$	2,494,278
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Non-Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
5. Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
6. Motor Vehicles				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	139,149
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	69,898
	Patient Trust Funds	67,343		
	Long Term Deposit - primicare	2,555		
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
	Name and Address	Amount	Loan Date	
7. Other Assets (<i>itemize</i>)			\$	
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	209,047
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	2,703,326

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

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Westside Care Center, LLC		2151-C	9/30/2017	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	489,754
2. Notes Payable (<i>itemize</i>)				\$	926,844
Working Capital Line of Credit					926,844
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>)				\$	437,466
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	3,816,315
Related Party Payables					3,138,986
Accrued Expenses					(25,797)
Accrued Resident User Fees					286,355
Accrued Workers Comp Expense					416,771
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	5,670,379

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Westside Care Center, LLC		License No. 2151-C	Report for Year Ended 9/30/2017	Page 34	of 37
Account				Amount	
Total Brought Forward:				5,670,379	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)				\$	
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$	
Name and Address of Lender	Amount	Loan Date			
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ 67,343	
Patient Trust Funds		67,343			
Long Term Note Securecare Realty					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 67,343	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 5,737,721	

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

Name of Facility		License No.	Report for Year Ended	Page	of
Westside Care Center, LLC		2151-C	9/30/2017	35	37
Account				Amount	
A. Reserves					
1. Reserve for value of leased land				\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized				\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)				\$	
4. Reserve for leasehold real properties on which fair rental value is based				\$	
5. Reserve for funds set aside as donor restricted				\$	
6. Total Reserves				\$	
B. Net Worth					
1. Owner's Capital				\$	25,000
2. Capital Stock				\$	
3. Paid-in Surplus				\$	
4. Treasury Stock				\$	
5. Cumulated Earnings				\$	(2,742,668)
6. Gain or Loss for Period				\$	(316,728)
7. Total Net Worth				\$	(3,034,396)
C. Total Reserves and Net Worth				\$	(3,034,396)
D. Total Liabilities, Reserves, and Net Worth				\$	2,703,326

H. Changes in Total Net Worth

Name of Facility		License No.	Report for Year Ended	Page	of
Westside Care Center, LLC		2151-C	9/30/2017	36	37
Account				Amount	
A.	Balance at End of Prior Period as shown on Report of 09/30/2016			\$	
B.	Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	14,321,355
C.	Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	14,638,083
D.	Net Income or Deficit			\$	(316,728)
E.	Balance			\$	(316,728)
F.	Additions				
	1. Additional Capital Contributed <i>(itemize)</i>				
	2. Other <i>(itemize)</i>				
F-3.	Total Additions			\$	
G.	Deductions				
	1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
	Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
	2. Other Withdrawings <i>(Specify)</i>			\$	
	Purpose		Amount		
	3. Total Deductions			\$	
H.	Balance at End of Period		09/30/17	\$	(316,728)

I. Preparer's/Reviewer's Certification

Name of Facility Westside Care Center, LLC	License No. 2151-C	Report for Year Ended 9/30/2017	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> NurseFac-Aids		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
iCare Management LLC				
Address			Phone Number	
341 Bidwell Street, Manchester, CT 06040			860-570-2140	