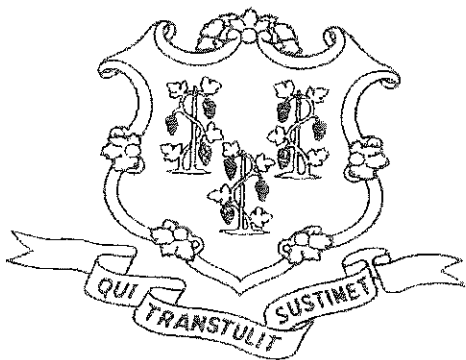


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2015

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 type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS)
<input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH 2151-C	RHNS	(Specify)	Medicare Provider 07-5252
------------------	----------------	------	-----------	------------------------------

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)	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2151-C	9/30/2015	1	37

Administrator's/Owner's Certification

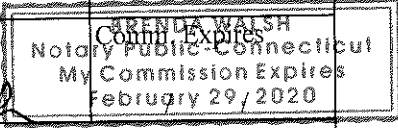
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Westside Care Center, LLC [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, 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
<i>David N. Sones</i>	2/10/16	<i>Chris Wright</i>	2/10/16
Printed Name (Administrator)		Printed Name (Owner)	
David Sones		Chris Wright	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)
<i>David Sones</i>	CT	2/10/16	<i>Runda Walsh</i>
Address of Notary Public			
<i>341 Bidwell Street, Manchester, CT 06040</i>			



(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 10/1/2014	To 9/30/2015
Address of Facility 349 Bidwell Street, Manchester, CT 06040				
Report Prepared By Denise MacKinnon		Phone Number 860-570-2140 ext 15	Date	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-647-9191		Report for Year Ended 9/30/2015	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	(Specify)	Medicare Provider No. 07-5252
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?				
<input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator David Sones		Nursing Home Administrator's License No.:	000853 1704	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

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Related Parties*

Name of Facility		License No.	Report for Year Ended	Page	of
Westside Care Center, LLC			9/3/2015	4	37
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties		Indicate Where Costs are Included in Annual Report Page # / Line #	Actual Cost to the Related Party
		Yes	No		
Bidwell Care Center, LLC	333 Bidwell St. Manchester, CT 06040				15,948
Chelsea Place Care Center, LLC	25 Lorraine St. Hartford, CT 06105				-
Chestnut Point Care Center, LLC	171 Main St. East Windsor, CT 06088			19 3	-
Chestnut Point Care Center, LLC	171 Main St. East Windsor, CT 06088				-
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032			16 M	(810)
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032				(1,627)
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088			19 3	-
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088				-
Meriden Care Center, LLC (Silver Springs)	33 Roy St. Meriden, CT 06450				-
Trinity Hill Care Center, LLC	151 Hillside Ave. Hartford, CT 06106				8,632
Westside Care Center, LLC	349 Bidwell St. Manchester, CT 06040				-
Wintonbury Care Center, LLC	140 Park Ave. Bloomfield, CT 06002				-
Secure Care Center LLC	60 West Street, Rocky Hill, CT 06067				1,722
Touchpoints therapy	171 Main St. East Windsor, CT 06088			13 5, 8, 10	345,432
Bidwell Realty, LLC	341 Bidwell St. Manchester, CT 06040			22,22,27 10,9,14	804,063
iCare Management, LLC	341 Bidwell St. Manchester, CT 06040			16, 15 M,E	24,452
iCare Health Management, LLC	341 Bidwell St. Manchester, CT 06040				155,441
				20 51	149,549
				20 51	53,131
				16 M12	328,068
					-
					-
					-
					-
					-
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
 Related Parties***

Name of Facility Westside Care Center, LLC		License No. 2151-C	Report for Year Ended 9/30/2015	Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input type="radio"/> Yes <input checked="" type="radio"/> 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? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," provide the following information:							
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties		Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No %**				
See Attached		<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.
 ** 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 9/30/2015	Page 5	of 37
If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:				
Item	Method of Allocation			
Dietary	Number of meals served to residents			
Laundry	Number of pounds processed			
Housekeeping	Number of square feet serviced			
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants			
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (<i>See listing page 13</i>)			
Maintenance and operation of plant	Square feet			
Property costs (depreciation)	Square feet			
Employee health and welfare	Gross salaries			
Management services	Appropriate cost center involved			
All other General Administrative expenses	Total of Direct and Allocated Costs			
The preparer of this report must answer the following questions applicable to the cost information provided.				
1. In the preparation of this Report, were all costs allocated as required? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.				
2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.				
3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)				
<input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.				

General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility Westside Care Center, LLC		License No. 2151-C	Report for Year Ended 9/30/2015		Page 6	of 37
			Date of Lease**	Term of Lease		
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					
Accelerated Care Plus Corp. 4850 Jolie Street, Suite A-1 Reno, NV	<input type="radio"/>	OmniStim Electrotherapy and Omnisound Therapeutic Ultrasound Equipment	05/18/10	automatic annual	8,303	8,303
ADP, Inc., One ADP Drive MS-100, Augusta, GA 30909	<input type="radio"/>	Time Clocks and Payroll Punch Equip	06/01/10	60 Months	8,444	8,444
GE Capital C/O Ricoh USA, P.O.Box 41564, Philadelphia, PA 19101	<input type="radio"/>	Copier	07/10/12	48 months	4,594	4,594
GE Capital C/O Ricoh USA, P.O.Box 41564, Philadelphia, PA 19101	<input type="radio"/>	Copier	11/20/14	48 months	8,891	8,891
Mail Finance/Neopost New England, 25881 Newtwork Place, Chicago, IL 60673	<input type="radio"/>	Postage Meter Rental		Monthly	829	829
GE Capital C/O Ricoh USA, P.O.Box 41564, Philadelphia, PA 19101	<input type="radio"/>	Copier	06/23/14	48 months	2,669	2,669
	<input type="radio"/>					
	<input type="radio"/>					
	<input type="radio"/>					
	<input type="radio"/>					
	<input type="radio"/>					
	<input type="radio"/>					
					Total ***	33,730

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

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

** Attach copies of newly acquired leases.

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

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**General Information and Questionnaire
Accounting Basis**

Name of Facility Westside Care Center, LLC	License No. 2151-C	Report for Year Ended 9/30/2015	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 (*describe fully*)

1 Taxes, financial statements, accounting support	\$ 3,712
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 3,712

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,Robinson)) 5 Starble and Harris, iCare Health Management LLC	Telephone Number 860-570-2140 860-678-7775 860-275-8200
---	--

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

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 (*describe fully*)

1 Lease and contract issues, general legal advice, Labor Law	\$ 21,663
2 Lease and contract issues, general legal advice, union funds advice	\$ 4,144
3 Employment law, arbitrations, contract negotiations	\$ 924
4 Employment Arbitrations, healthcare law	\$ 4,160
5 Collections	\$ 10,209
	Charge for Services Provided
	\$ 41,101

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	License No.	Report for Year Ended						Page	of				
		9/30/2015								8	37		
		Period 10/1 Thru 6/30		Period 7/1 Thru 9/30		Total	RHNS (Specify)					CCNH	RHNS (Specify)
Westside Care Center, LLC	2151-C	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)			Total	RHNS	CCNH	RHNS		
I. Certified Bed Capacity		180	180			180		180		162		162	
A. On last day of PREVIOUS report period													
B. On last day of THIS report period		162	162			162		162		162		162	
2. Number of Residents		158	158			158		158		143		143	
A. As of midnight of PREVIOUS report period													
B. As of midnight of THIS report period		154	154			143		143		154		154	
3. Total Number of Days Care Provided During Period		2,404	2,404			1,963		1,963		441		441	
A. Medicare		52,218	52,218			39,223		39,223		12,995		12,995	
B. Medicaid (Conn.)													
C. Medicaid (other states)													
D. Private Pay		401	401			325		325		76		76	
E. State SSI for RCH													
F. Other (Specify) INSURANCE		243	243			214		214		29		29	
G. Total Care Days During Period (3A thru F)		55,266	55,266			41,725		41,725		13,541		13,541	
Total Number of Days Not Included in Figures in 3G													
4. 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)		55,266	55,266			41,725		41,725		13,541		13,541	

Schedule of Resident Statistics (Cont'd)

Name of Facility Westside Care Center, LLC			License No. 2151-C			Report for Year Ended 9/30/2015			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input checked="" type="radio"/> Yes <input 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	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
6/1/2015	X			18									
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days							CCNH	RHNS	(Specify)				
1st change							146						
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	7		145		2								
Per Diem Rate													
a. One bed rm.													
b. Two bed rms.	431.00		237.00		458.00								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments							TOTAL	CCNH	RHNS	(Specify)			
A. Medicare - Part B							2,483	2,483					
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments							2,016	2,016					
C. Other							2,516	2,516					
D. Total Physical Therapy Treatments							7,015	7,015					
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B							370	370					
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments							311	311					
C. Other							430	430					
D. Total Speech Therapy Treatments							1,111	1,111					
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B							3,189	3,189					
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments							2,443	2,443					
C. Other							2,777	2,777					
D. Total Occupational Therapy Treatments							8,409	8,409					

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Westside Care Center, I.L.C.	2151-C	9/30/2015	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	142,661	2,086				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	119,569	6,330				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	68,590	2,644				
c. Dietary Workers	504,533	28,062				
6. Housekeeping Service						
a. Head Housekeeper		1,009				
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	50,451	1,968				
b. Other Maintenance Workers	50,169	2,239				
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	180,947	3,605				
b. RN						
1. Direct Care	255,082	5,698				
2. Administrative**	236,280	6,247				
c. LPN						
1. Direct Care	1,551,742	51,589				
2. Administrative**						
d. Aides and Attendants	2,535,175	134,705				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	161,528	8,358				
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	163,412	6,199				
n. Marketing						
o. Other (Specify) See Attached Schedule	81,631	4,147				
<i>A-13. Total Salary Expenditures</i>	<i>6,101,767</i>	<i>264,886</i>				

* 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.

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

Name of Facility		License No.		Report for Year Ended		Page	of		
Westside Care Center, LLC		2151-C		9/30/2015		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)							
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 9/30/2015		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 (Specify)							
Section III - Administrators***									
Ray Hackling (10/1/2014-9/30/2015)	142,661		same as employees less union funds	Administrator	2,086	A2			
			same as employees less union funds	Administrator		A2			
			same as employees less union funds	Administrator		A2			
Section IV - Assistant Administrators									

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Westside Care Center, LLC	2151-C	9/30/2015	13	37		
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian	45,495	1,009				
2. Dentist						
3. Pharmacist	10,558	236				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	148,440	1,895				
b. Other						
6. Social Worker	4,164	training				
7. Recreation Worker	17,132	54+Cable				
8. Physicians						
a. Medical Director (entire facility)	33,600	281				
b. Utilization Review (Title 18 and 19 only) monthly meeting	292	2				
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	27,650	329				
9. Speech Therapist						
a. Resident Care	34,332	493				
b. Other						
10. Occupational Therapist						
a. Resident Care	162,115	2,257				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	149,952	2,257				
2. Administrative***	9,799	268				
b. LPN						
1. Direct Care	3,392	81				
2. Administrative***						
c. Aides	(1,179)	(88)				
d. Other						
12. Other (Specify) See Attached Schedule	166,067	4,598				
B-13 Total Fees Paid in Lieu of Salaries	811,808	13,618				

* 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 9/30/2015	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"/>			
Tocuhpoints Therapy	Therapy	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver	Shared Employees	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Healthcare Dental	Audiology, Dental and Podiatry	<input type="radio"/>	<input checked="" type="radio"/>			
Ready Nurse, Nurse Network	Nursing pool (RN, LPN, CNA)	<input type="radio"/>	<input checked="" type="radio"/>			
IPC Hospitalists	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input 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	9/30/2015	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 491,110	491,110		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$			
4. Social Security (F.I.C.A.)	\$ 539,896	539,896		
5. Health Insurance	\$ 1,076,859	1,076,859		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 355,030	355,030		
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$ 46,416	46,416		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 270,844	270,844		
d. Accounting and Auditing	\$ 3,712	3,712		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 41,101	41,101		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 14,985	14,985		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 34,396	34,396		
2. Cellular Phones	\$ 1,307	1,307		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 252	252		
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$			
2. Other (<i>Specify</i>) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 1,161,691	1,161,691		
Subtotal	\$ 4,037,599	4,037,599		

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

(Carry Subtotals forward to next page)

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	9/30/2015	16	37
Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	4,037,599	4,037,599		
1. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$			
3. Gifts to Staff and Residents	\$			
4. Employee Travel	\$ 1,159	1,159		
5. Education Expenses Related to Seminars and Conventions	\$ 1,857	1,857		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 318	318		
7. Other (<i>Specify</i>)	\$ 586	586		
See Attached Schedule				
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 6,734	6,734		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$			
3. Advertising Other (<i>Specify</i>)***	\$ 8,151	8,151		
See Attached Schedule				
4. Fund-Raising***	\$			
5. Medical Records	\$			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$			
7. Postage	\$ 5,106	5,106		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>)	\$ 12,196	12,196		
See Attached Schedule				
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$ 499	499		
10. Contributions***	\$ 610	610		
See Attached Schedule				
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 110,579	110,579		
12. Administrative Management Services**	\$ 328,068	328,068		
13. Other (<i>Specify</i>)	\$ 31,934	31,934		
See Attached Schedule				
C-14 Total Administrative & General Expenditures	\$ 4,545,398	4,545,398		

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

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
MEALS	\$ 586		\$ -
Total Other Travel and Entertainment	\$ 586	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
COMMUNICATIONS SPECIAL EVENTS	\$ 8,151		\$ -
Total Other Advertising	\$ 8,151	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Dues			
CAHCF Dues	\$ 12,196.25		\$ -
OTHER DUES			
Total Dues	\$ 12,196	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
CHARITABLE CONTRIBUTIONS	\$ 610		\$ -
Total Contributions	\$ 610	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
SOCIAL SERVICE SUPPLIES	\$ 117		\$ -
SOC SVC MINOR EQUIPMENT	\$ -		\$ -
ADMINISTRATIVE MINOR EQUIPMENT	\$ 1,553		\$ -
EMPLOYEE RELATIONS	\$ 4,965		\$ -
EMPLOYEE RELATIONS-OTHER	\$ 361		\$ -
PERMITS & LICENSES	\$ 3,451		\$ -
VOLUNTEER EXPENSE	\$ -		\$ -
BANK FEES	\$ 11,324		\$ -
CMS REVISIT USER FEES	\$ -		\$ -
PENALTIES	\$ 5,803		\$ -
LATE FEES	\$ 4,361		\$ -
Rounding			
Total Other Administrative and General	\$ 31,934	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Westside Care Center, LLC	2151-C	9/30/2015	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	328,068	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	149,549	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	53,131	MANAGEMENT FEES- INDIRECT CARE	Pg 20 j

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Westside Care Center, LLC		2151-C	9/30/2015		18	37
Item		Total	CCNH	RHNS	(Specify)	
2. Dietary						
a. In-House Preparation & Service						
1.	Raw Food	\$ 331,634	331,634			
2.	Non-Food Supplies	\$ 36,282	36,282			
3.	Other (Specify) _____ DIETARY SUPPLEMENTS	\$ 36,186	36,186			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$ (14,489)	(14,489)			
c. Management Services**		\$				
d. Other (Specify) _____ DIETARY MINOR EQUIPMENT		\$ 8,005	8,005			
2E. Total Dietary Expenditures (2a + b + c + d)		\$ 397,617	397,617			
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)	
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		License No.	Report for Year Ended		Page	of
Westside Care Center, LLC		2151-C	9/30/2015		19	37
Item		Total	CCNH	RHNS	(Specify)	
3. Laundry						
a. In-House Processing*		Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$	1,324	1,324		
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)		\$	455,749	455,749		
c. Management Services**		\$				
d. Other (Specify) LAUNDRY SUPPLIES		\$	284	284		
3E. Total Laundry Expenditures (3a + b + c + d)		\$	457,357	457,357		
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	9/30/2015		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	27,375	27,375		
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. \$	520,308	520,308		
c.	Management Services*	\$				
d.	Other (<i>Specify</i>) HOUSEKEEPING MINIR EQUIPMENT	\$				
4E.	Total Housekeeping Expenditures (4a + b + c + d)	\$	547,683	547,683		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from OMNICARE PHARMACY	\$	81,087	81,087		
b.	Medicine Cabinet Drugs	\$	16,671	16,671		
c.	Medical and Therapeutic Supplies	\$	74,222	74,222		
d.	Ambulance/Limousine***	\$	4,770	4,770		
e.	Oxygen					
	1. For Emergency Use	\$	6,108	6,108		
	2. Other***	\$				
f.	X-rays and Related Radiological Procedures***	\$	2,650	2,650		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	4,680	4,680		
i.	Recreation	\$				
j.	Other (Specify)**** See Attached Schedule	\$	327,320	327,320		
5K.	Total Resident Care Expenditures (5a - 5j)	\$	517,507	517,507		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
NURSING ADMIN SUPPLIES	\$ 434		\$ -
NURSING MINOR EQUIP	\$ 3,903		\$ -
MEDICAL RECORDS SUPPLIES	\$ -		\$ -
MEDICAL RECORDS MINOR EQUIPMENT	\$ -		\$ -
MANAGEMENT ALLOCATIONS - DIRECT	\$ 149,549		\$ -
NON-COVERED PPS DR. VISITS	\$ 873		\$ -
RESIDENT CARE SUPPLIES	\$ 21		\$ -
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 8,289		\$ -
PERSONAL CARE SUPPLIES	\$ 6,481		\$ -
INCONTINENCY SUPPLIES	\$ 29,016		\$ -
VACCINE RESIDENTS	\$ 5,139		\$ -
PATIENT SPECIAL NEEDS	\$ 3,509		\$ -
PHYSICAL THERAPY SUPPLIES	\$ 79		\$ -
PHYSICAL THERAPY EQUIPMENT RENT	\$ -		\$ -
PHYSICAL THERAPY MINOR EQUIPMENT	\$ -		\$ -
OCCUPATIONAL THERAPY SUPPLIES	\$ 63		\$ -
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	\$ 43,598		\$ -
EQUIPMENT RENTAL: AIDS UNIT	\$ -		\$ -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ 61		\$ -
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ -		\$ -
HI LOW BED RENTAL & MATTRESSES	\$ -		\$ -
IV THERAPY SUPPLIES	\$ 15,377		\$ -
IV THERAPY CONTRACT SERVICE	\$ -		\$ -
MEDICAL WASTE CONTRACT SERVICE	\$ 2,154		\$ -
ACTIVITIES SUPPLIES	\$ 5,641		\$ -
ACTIVITIES MINOR EQUIPMENT	\$ -		\$ -
MANAGEMENT ALLOCATION - INDIRECT	\$ 53,131		\$ -
ADMISSIONS SUPPLIES	\$ -		\$ -
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$ -		\$ -
Total Other Resident Care	\$ 327,320	\$ -	\$ -

**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 9/30/2015	Page 21	of 37				
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Full Explanation of Service Provided*	CCNH	RHNS	(Specify)	Pg	Line
		Yes	No						
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	<input type="radio"/>	<input type="radio"/>	Housekeeping Services	517,921			20	4b
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	<input type="radio"/>	<input type="radio"/>	Laundry Services	453,658			19	3b
Eagle Elevator		<input type="radio"/>	<input type="radio"/>	Elevator Contract	6,126			22	6F
Bioserve, Inc.		<input type="radio"/>	<input type="radio"/>	Medical Waste Snow	2,154			22	6F
The Brickman Group/ A1 Landscaping		<input type="radio"/>	<input type="radio"/>	Removal/Landscaping	20,710			22	6F
CWPM - Recycling		<input type="radio"/>	<input type="radio"/>	Trash removal	19,746			22	6F
American Health Tech		<input type="radio"/>	<input type="radio"/>	Software Maintenance Contract	10,713			16	M11
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	<input type="radio"/>	<input type="radio"/>	Payroll Services	48,282			16	M11
National Datacare Corp		<input type="radio"/>	<input type="radio"/>	Resident Trust Software	2,773			16	M11
Prime Care Technology services		<input type="radio"/>	<input type="radio"/>	Computer Consulting Services	23,330			16	M11
Priority Express		<input type="radio"/>	<input type="radio"/>	Courier Services	6,498			16	M11
Point Right Inc		<input type="radio"/>	<input type="radio"/>	Nursing Software	4,680			16	M11
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input 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
Westside Care Center, LLC	2151-C	9/30/2015			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 39,100	39,100				
b. Heat	\$ 52,677	52,677				
c. Light & Power	\$ 160,869	160,869				
d. Water	\$ 66,438	66,438				
e. Equipment Lease (Provide detail on page 6)	\$ 33,730	33,730				
f. Other (itemize)	\$ 82,627	82,627				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 435,441	435,441				
7. Depreciation (complete schedule page 23*)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$ 11,119	11,119				
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 58,707	58,707				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 69,826	69,826				
8. Amortization (Complete att. Schedule Page 24*)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 33,626	33,626				
d. Other (Specify)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 33,626	33,626				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 606,000	606,000				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 120,981	120,981				
c. Personal property taxes	\$ 10,839	10,839				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 841,273	841,273				

* Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 24.

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
PLANT SUPPLIES	\$ 11,900		\$ -
PLANT CONTRACT SERVICE LABOR	\$ 2,166		\$ -
ELEVATOR CONTRACT SERVICE	\$ 3,829		\$ -
FIRE/SPRINKLER CONTRACT SERVICE	\$ 8,143		\$ -
LANDSCAPING CONTRACT SERVICE	\$ 11,950		\$ -
SNOW REMOVAL CONTRACT SERVICE	\$ 8,760		\$ -
TRASH REMOVAL CONTRACT SERVICE	\$ 19,746		\$ -
HVAC CONTRACT SERVICE	\$ -		\$ -
SECURITY CONTRACT SERVICE	\$ -		\$ -
PLANT CONTRACT SERVICE OTHER	\$ 4,901		\$ -
PLANT MINOR EQUIPMENT	\$ 11,233		\$ -
RENT AUTO	\$ -		\$ -
RENT EQUIPMENT	\$ -		\$ -
RENT OTHER	\$ -		\$ -
Total Other Repairs and Maintenance	\$ 82,627	\$ -	\$ -

Depreciation Schedule

Name of Facility		License No.		Report for Year Ended					Page	of
Westside Care Center, LLC		2151-C		9/30/2015					23	37
Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals		
										Is a mileage logbook maintained?
	Yes	No	Month	Year						
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	179,396		179,396	38			8,969			
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	145,224		145,224				2,150			
B-4. Subtotal								11,119		
C. Non-Movable Equipment										
1. Acquired prior to this report period										
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)										
C-4. Subtotal										
D. Movable Equipment										
1. Motor Vehicles (Specify name, model and year of each vehicle)										
a.			2,306	2,306						
b.										
c.										
d.										
2. Movable Equipment										
a. Acquired prior to this report period			928,972	696,497			55,319			
b. Disposals (attach schedule)										
c. Acquired during this report period (attach schedule)							3,388			
D-3. Subtotal			39,276					58,707		
E. Total Depreciation								69,826		

Westside Care Center, LLC
9/30/2015

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:				
2/1/2015	Air Conditioning Units	\$ 9,146	120	\$ 534
9/1/2015	Air Conditioning Units	\$ 128,140	120	\$ 1,068
4/1/2015	Kitchen Disposal	\$ 4,535	60	\$ 378
3/1/2015	Circulating Pump	\$ 3,403	120	\$ 170
Total additions for Building Improvements		\$ 145,224		\$ 2,150 *
Deletions:				
Total deletions for Building Improvements		\$ -		\$ - **

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

Schedule of Non-Movable Equipment Acquired during this report period

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/3/2014	Replaced Dishwasher Motor: Hobart Srv	\$ 3,653	120	\$ 335
12/21/2014	Food Processor:Direct Supply	\$ 1,523	60	\$ 228
12/29/2014	Panacea Bed: Direct Supply	\$ 1,601	60	\$ 240
2/23/2015	Mattress: Direct Supply	\$ 5,533	60	\$ 646
1/12/2015	Mattress: Direct Supply	\$ 1,741	60	\$ 232
2/5/2015	Replaced Circuit Board Ice Machine: Saucier Mechanical Serv.	\$ 1,598	120	\$ 93
10/24/2014	Upgrade Washer: Healthcare service	\$ 3,735	120	\$ 280
4/14/2015	Control Box for bed: Direct Supply	\$ 2,510	60	\$ 209
6/16/2015	Washer Upgrade: Daniels Equipment	\$ 2,954	60	\$ 98
8/24/2015	Degital Scale: HD Supply	\$ 3,882	120	\$ 32
10/31/2014	Computer: Prime Care Tech	\$ 1,825	36	\$ 557
6/1/2015	Mattresses	\$ 8,722	60	\$ 436
Total additions for Movable Equipment		\$ 39,276		\$ 3,388 *
Deletions:				
Total deletions for Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/3/2014	Auto Extunguisher Repair: Central Systems inc	\$ 1,979	120	\$ 181
5/5/2015	Upgrade Ansul System: All State Fire Equipment	\$ 3,829	120	\$ 128
Total additions for Leasehold Improvement		\$ 5,808		\$ 309 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Westside Care Center, LLC	License No. 2151-C		Report for Year Ended 9/30/2015		Page 24	of 37			
	Date of Acquisition Month Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations			Basis for Computing Amortization**	Rate %	Amortization for This Year
A. Organization Expense									
1. Organization Expense		5	4,319	4,319					
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			403,694	174,022			33,317		
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)			5,808				309		
C-4. Subtotal									
D. Total Amortization									
									33,626
									33,626

* 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 9/30/2015	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input 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 NOT Original Owner, Date of Purchase		12/01/03			
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		319.00%			
d. Term of Mortgage (number of years)		24			
e. Amount of Principal Borrowed		3,519,700			
f. Principal balance outstanding as of 09/30/2015		3,278,921			
Complete if Mortgage was Refinanced During Current Cost Year					
g. Type of Financing (e.g., fixed, variable)					
h. Date of Refinancing					
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed					
l. Principal Outstanding on Note Paid-Off					
Part C - Arms-Length Leases for Real Property Improvements Only					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Westside Care Center, LLC		2151-C	9/30/2015		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Westside Care Center, LLC		2151-C		9/30/2015		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$			
12. D. Other Interest Expense (Specify)				\$	45,442	45,442	
INTEREST							
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	45,442	45,442	
14. Insurance							
a. Insurance on Property (buildings only)				\$	9,102	9,102	
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$	67,980	67,980	
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$	3,879	3,879	
14d. Total Insurance Expenditures (14a + b + c)				\$	80,961	80,961	
15. Total All Expenditures (A-13 thru C-14)				\$	14,782,254	14,782,254	

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Westside Care Center, LLC			2151-C	9/30/2015	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$	270,844	270,844	
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 *	\$	8,151	8,151	
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$	57,191	57,191	
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)				\$	336,186	336,186	

(Carry Subtotal forward to next page)

* All except "Help Wanted".

** 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	(Specify)
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16		Management fee over cost	\$ -		\$ -
Total Other Fees Adjustments			\$ -	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16a		PENALTIES	\$ 5,803		\$ -
16a		LATE FEES	\$ 4,361		\$ -
16a		PRIOR PERIOD EXPENSES			
		rounding	0		
		Provider user fee Medicare days	47,027.48		
Total Other A&G Adjustments			\$ 57,191	\$ -	\$ -

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	9/30/2015	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 336,186	336,186		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$			
28.			Ambulance/Limousine	\$ 4,770	4,770		
29.			X-rays, etc	\$ 2,650	2,650		
30.			Laboratory	\$ 4,680	4,680		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 873	873		
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)				\$ 349,159	349,159		

*** 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
9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5J	NON-COVERED PPS DR. VISITS	873.13		-
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			\$ 873	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

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

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

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Westside Care Center, LLC	2151-C	9/30/2015			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (CT only)	\$ 12,317,384	12,317,384				
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)	\$ 968,607	968,607				
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$ 294,377	294,377				
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 61,986	61,986				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (61,986)	(61,986)				
c. Prescription Drugs - Non-Medicare	\$ 19,668	19,668				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (19,668)	(19,668)				
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	\$ 150,057	150,057				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (73,715)	(73,715)				
c. Physical Therapy - Non-Medicare	\$ 85,572	85,572				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (85,572)	(85,572)				
4. a. Speech Therapy - Medicare	\$ 53,497	53,497				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (23,468)	(23,468)				
c. Speech Therapy - Non-Medicare	\$ 23,534	23,534				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (23,534)	(23,534)				
5. a. Occupational Therapy - Medicare	\$ 198,749	198,749				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (93,868)	(93,868)				
c. Occupational Therapy - Non-Medicare	\$ 106,354	106,354				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (79,710)	(79,710)				
6. a. Other (Specify) - Medicare	\$					
b. Other (Specify) - Non-Medicare	\$ 63,580	63,580				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 13,881,843	13,881,843				
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)	\$ 63	63				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (Specify)	\$ 8,971	8,971				
V. Total Other Revenue (1 thru 8)	\$ 9,034	9,034				
VI. Total All Revenue (III + V)	\$ 13,890,877	13,890,877				

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Lab Medicare	\$ 33,547		
	Lab Medicare CA	\$ (33,547)		
	Oxygen Medicare	\$ 158		
	Oxygen Medicare CA	\$ (158)		
	Equipment rental	\$ 1,473		
	Equipment rental CA	\$ (1,473)		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds Medicare	\$ -		
	Therapy Beds Medicare CA	\$ -		
	Radiology Medicare	\$ 1,951		
	Radiology Medicare CA	\$ (1,951)		
	IV Therapy	\$ 17,648		
	IV Therapy CA	\$ (17,648)		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose testing	\$ -		
	Glucose testing CA	\$ -		
	Outpatient therapy Medicare	\$ -		
	Total Other Resident Revenue - Medicare	\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Lab	2,150.79		
	Lab CA	(2,150.79)		
	Oxygen	\$ 2,504		\$ -
	Oxygen CA	\$ (2,504)		\$ -
	Equipment rental	\$ 14,804		
	Equipment rental CA	\$ (14,804)		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds	\$ -		
	Therapy Beds CA	\$ -		
	Radiology	\$ 667		
	Radiology CA	\$ (667)		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose Testing	\$ -		
	Glucose Testing CA	\$ -		
	IV therapy	\$ 23,088		\$ -
	IV therapy CA	\$ (23,088)		\$ -
	Flu shot revenue	\$ 4,139		
	Outpatient therapy	\$ -		
	PRIOR YEAR ADJ - ANCILLARY & OTHER	\$ 59,441		
	rounding	\$ (0)		
	Total Other Resident Revenue	\$ 63,580	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	INTEREST INCOME		\$ 63		
	Total Interest Income		\$ 63	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	MEALS	\$ -		
	TELEVISION INCOME	\$ -		
	CONCESSIONS / VENDING INCOME	\$ 1,891		
	RESIDENT LATE FEE REVENUE	\$ -		
	RESIDENT ATTORNEY FEE REVENUE	\$ -		
	TELEPHONE INCOME	\$ -		
	OTHER INCOME	\$ -		
	OPTUM DIVIDENDS REVENUE	\$ 7,080		
	Total Other Revenue	\$ 8,971	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Westside Care Center, LLC	2151-C	9/30/2015	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	(221,220)
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,280,409
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	50,986
4. Inventories			\$	
5. Prepaid Expenses			\$	194,441
a. Prepaid Insurance	162,176			
b. Prepaid Property Taxes	2,455			
c. Prepaid Expenses Other	29,810			
d.				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	(646,900)
Due From (to) Related Parties	(59,489)			
Other Owners reserves	(587,412)			
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,657,716
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost		\$	
	Accum. Depreciation	Net		
3. Buildings	*Historical Cost	324,621	\$	313,464
	Accum. Depreciation	11,157 Net		
4. Leasehold Improvements	*Historical Cost	409,502	\$	201,853
	Accum. Depreciation	207,648 Net		
5. Non-Movable Equipment	*Historical Cost		\$	
	Accum. Depreciation	Net		
6. Movable Equipment	*Historical Cost	968,248	\$	213,044
	Accum. Depreciation	755,204 Net		
7. Motor Vehicles	*Historical Cost	2,306	\$	
	Accum. Depreciation	2,306 Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	15,895
Construction in Progress	15,895			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	744,256

* 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	9/30/2015	32	37
Account				Amount	
Total Brought Forward:				\$	2,401,972
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					
\$					
3. Organization Expense					
		*Historical Cost	4,319		
		Accum. Depreciation	4,319	Net	\$
4. Goodwill (Purchased Only)					
\$					
5. Investments Related to Resident Care (<i>itemize</i>)					
		Patient Trust Funds	67,343		
		Long Term Deposit - primicare	2,555		
\$ 69,898					
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)					
\$ 69,898					
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)					
\$ 2,471,870					

* 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	9/30/2015	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	718,619
2. Notes Payable (<i>itemize</i>)				\$	1,390,914
Working Capital Line of Credit					1,390,914
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>)				\$	471,649
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>)				\$	2,506,699
Related Party Payables		2,363,904			
Accrued Expenses		22,859			
Accrued Resident User Fees		278,068			
Accrued Workers Comp Expense		(158,132)			
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	5,087,880

* 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 9/30/2015	Page 34	of 37
Account				Amount
Total Brought Forward:				5,087,880
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				
Name of Lender	Purpose	Amount	Date Due	\$
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$
Name and Address of Lender	Amount	Loan Date	\$	
4. Other Long-Term Liabilities (<i>itemize</i>)				\$
Patient Trust Funds		67,343	67,343	
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 67,343
C. Total All Liabilities (Lines A-13 + B-5)				\$ 5,155,223


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	9/30/2015	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			\$	(1,816,601)
6. Gain or Loss for Period			\$	(891,752)
	10/1/2014	thru 9/30/2015		
7. Total Net Worth			\$	(2,683,353)
C. Total Reserves and Net Worth			\$	(2,683,353)
D. Total Liabilities, Reserves, and Net Worth			\$	2,471,870

H. Changes in Total Net Worth

Name of Facility		License No.	Report for Year Ended	Page	of
Westside Care Center, LLC		2151-C	9/30/2015	36	37
Account				Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2014				\$	
B. Total Revenue (From Statement of Revenue Page 30)				\$	13,890,877
C. Total Expenditures (From Statement of Expenditures Page 27)				\$	14,782,254
D. Net Income or Deficit				\$	(891,377)
E. Balance				\$	(891,377)
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				\$	(891,377)

I. Preparer's/Reviewer's Certification

Name of Facility Westside Care Center, LLC		License No. 2151-C	Report for Year Ended 9/30/2015	Page 37	of 37
<i>Check appropriate category</i>					
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)			
Preparer/Reviewer Certification					
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>					
Signature of Preparer 		Title VP Finance	Date Signed 2/10/16		
Printed Name of Preparer Denise MacKinnon					
Address Address 341 Bidwell Street, Manchester, CT 06040			Phone Number 860-570-2140 ext 15		