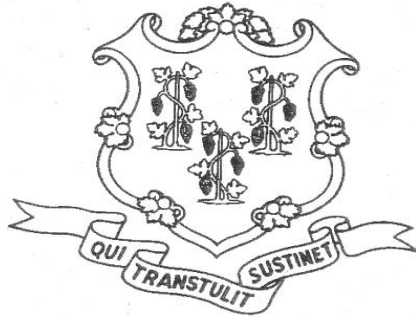


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2023

Name of Facility (as licensed) Westview Nursing Care & Rehabilitation Center, Inc.	
Address (No. & Street, City, State, Zip Code) 150 Ware Road, Dayville, CT 06241	
Type of Facility Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

License Numbers:	CCNH / RHNS 930-C	(Specify)	(Specify)	Medicare Provider 07-5078
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Medicaid Provider Numbers:	CCNH / RHNS 9308	(Specify)	(Specify)
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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Westview Nursing Care & Rehabilitation Center, Inc.	930-C	9/30/2023	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Westview Nursing Care & Rehabilitation Center, Inc. [facility name], for the cost report period beginning October 1, 2022 and ending September 30, 2023, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) David T. Panteleakos			Printed Name (Owner) Chaim Herbert Czermak		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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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 Westview Nursing Care & Rehabilitation Center, Inc.		Period Covered:	From 10/1/2022	To 9/30/2023
Address of Facility 150 Ware Road, Dayville, CT 06241				
Report Prepared By Janessa Choquette		Phone Number 860-774-8574 x 111	Date 2/15/2024	
Item	Total	CCNH / RHNS	(Specify)	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. 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 860-774-8574		Report for Year Ended 9/30/2023	Page 2	of 37
Name of Facility (as shown on license) Westview Nursing Care & Rehabilitation Center, Inc.		Address (No. & Street, City, State, Zip) 150 Ware Road, Dayville, CT 06241		
License Numbers:	CCNH / RHNS 930-C	(Specify)	(Specify)	Medicare Provider No. 07-5078
Type of Facility (Check appropriate box(es)) Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box) <input type="checkbox"/> Proprietorship <input type="checkbox"/> LLC <input type="checkbox"/> Partnership <input checked="" 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 T. Panteleakos		Nursing Home Administrator's License No.:	1129	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name N/A		License No.:		

General Information and Questionnaire
Corporate Owners

Name of Facility Westview Nursing Care & Rehabilitation Ce	License No. 930-C	Report for Year Ended 9/30/2023	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address	State(s) in Which Incorporated		
Westview Nursing Care & Rehabilitation Center, Inc.	150 Ware Road, Dayville, CT 06241	CT		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Chaim H. Czermak	1018 New McNail Avenue, Lawrence, NY 11559	resident/Treasur	200	
Marvin Czermak	1049 East 23rd Street, Brooklyn, NT 11210	VP/Secretary	100	
Maurice Katz (Chamideb Trust)	35 Broadway, Lawrence, NY 11559	Director	50	
Isabelle Katz	1 Regent Drive, Lawrence, NY 11559	Director	50	
David T. Panteleakos	68 Beaver Dam Rd., Woodstock, CT 06282	utive Vice Presi		
Names of Stockholders Owning at Least 10% of Shares				
Chaim H. Czermak	1018 New McNail Avenue, Lawrence, NY 11559	resident/Treasur	200	
Marvin Czermak	1049 East 23rd Street, Brooklyn, NT 11210	VP/Secretary	100	
Maurice Katz (Chamideb Trust)	35 Broadway, Lawrence, NY 11559	Director	50	
Isabelle Katz	1 Regent Drive, Lawrence, NY 11559	Director	50	
David T. Panteleakos	68 Beaver Dam Rd., Woodstock, CT 06282	utive Vice Presi		

General Information and Questionnaire Related Parties*

Name of Facility Westview Nursing Care & Rehabilitation Center, Inc.	License No. 930-C	Report for Year Ended 9/30/2023	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Westview Land Company	150 Ware Road, Dayville, CT 06241	<input type="radio"/>	<input checked="" type="radio"/>		Lessor	Pg. 22/Line 9	1,014,107	1,014,107
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Westview Nursing Care & Rehabilitation Center	License No. 930-C	Report for Year Ended 9/30/2023	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

General Information and Questionnaire
Other Lines of Business

Name of Facility Westview Nursing Care & Rehabilita	License No. 930-C	Report for Year Ended 9/30/2023	Page 6	of 37
Square footage of entire facility.		77,772		
Outpatient Therapy				
Does the Facility provide outpatient therapy services?		Yes		
<i>If yes, please complete the following:</i>				
6,522	Square footage of therapy space.			
Meals on Wheels				
Does the facility provide Meals on Wheels?		No		
<i>If yes, please complete the following:</i>				
	Square footage of kitchen			
	Number of meals served per week			
No	Are meals included in meals served on page 18 of the Annual Report?			
No	Are direct costs included in the Annual Report?			
	<i>If yes, please state where costs are reported.</i>			
No	Are drivers for the program included in the facility's payroll?			
	<i>If yes, please complete the following:</i>			
	Amount Reported			
	Annual Report page and line			
	Please state the salary amounts of specific cooks and/or dietary aides			
	Please state where the cooks and/or dietary aides are reported in the Annual Report			
Apartments, Independent Living, Assisted Living				
Does the facility have apartments, independent living, and/or assisted living?		No		
<i>If yes, please complete the following:</i>				
	Square footage of apartments			
	Square footage of independent living			
	Square footage of assisted living			
	Please identify the services provided:			

General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility Westview Nursing Ca	License No. 930-C	Report for Year Ended 9/30/2023	Page 7	of 37
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Child Day Care

Does the Facility provide Child Day Care? No

If yes, please complete the following:

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

Adult Day Care

Does the Facility provide Adult Day Care? No

If yes, please complete the following:

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

Schedule of Resident Statistics

Name of Facility			License No.		Report for Year Ended				Page		of	
Westview Nursing Care & Rehabilitation Center, Inc.			930-C		9/30/2023				8		37	
	Total All Levels	Total CCNH / RHNS Level	Total (Specify)	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH / RHNS	(Specify)	(Specify)	Total	CCNH / RHNS	(Specify)	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	103	103			103	103						
B. On last day of THIS report period	103	103							103	103		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	97	97			97	97						
B. As of midnight of THIS report period	100	100							100	100		
3. Total Number of Days Care Provided During Period												
A. Medicare	6,229	6,229			4,952	4,952			1,277	1,277		
B. Medicaid (Conn.)	16,938	16,938			12,342	12,342			4,596	4,596		
C. Medicaid (other states)												
D. Private Pay	11,854	11,854			8,916	8,916			2,938	2,938		
E. State SSI for RCH												
F. Other (Specify) Managed Care	1,474	1,474			1,030	1,030			444	444		
G. Total Care Days During Period (3A thru F)	36,495	36,495			27,240	27,240			9,255	9,255		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	94	94			77	77			17	17		
B. Other Bed Reserve Days	97	97			68	68			29	29		
5. Total Resident Days (3G + 4A + 4B)	36,686	36,686			27,385	27,385			9,301	9,301		

Schedule of Resident Statistics (Cont'd)

Name of Facility Westview Nursing Care & Rehabilitation Center, Inc	License No. 930-C	Report for Year Ended 9/30/2023	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year? Yes No
 If "YES", provide the following information:

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

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

Change in Resident Days	CCNH / RHNS	(Specify)	(Specify)
1st change			
2nd change			
3rd change			
4th change			

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH / RHNS	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	(Specify)	R.C.H.	ICF-MR
No. of Residents	18	51		31				
Per Diem Rate								
a. One bed rm.	Various	308.85		407.00				
b. Two bed rms.	Various	308.85		386.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B	3,884	3,884			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	57	57			
2. Restorative Treatments					
C. Other	17,627	17,627			
D. Total Physical Therapy Treatments	21,568	21,568			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	823	823			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other	1,314	1,314			
D. Total Speech Therapy Treatments	2,137	2,137			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	4,308	4,308			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	48	48			
2. Restorative Treatments					
C. Other	7,618	7,618			
D. Total Occupational Therapy Treatments	11,974	11,974			

Annual Report of Long-Term Care Facility

CSP-10 Rev. 3/2023

Report of Expenditures - Salaries & Wages

Name of Facility Westview Nursing Care & Rehabilitation Center, Inc.	License No. 930-C	Report for Year Ended 9/30/2023	Page 10	of 37
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Are time records maintained by all individuals receiving compensation? Yes No

Item	Total Cost and Hours								
	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
A. Salaries and Wages*									
1. Operators/Owners (Complete also Sec. I of Schedule A1)	150,412		2,080						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	328,882	(220,833)	2,080						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	800,742		24,849						
5. Dietary Service									
a. Head Dietitian	36,928		791						
b. Food Service Supervisor	98,653		2,164						
c. Dietary Workers	496,165		25,765						
6. Housekeeping Service									
a. Head Housekeeper	40,090		2,199						
b. Other Housekeeping Workers	209,115	(6,326)	11,946						
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance	128,384		2,200						
b. Other Maintenance Workers	226,938	(9,019)	11,420						
8. Laundry Service									
a. Supervisor	64,635		2,392						
b. Other Laundry Workers	169,461		9,454						
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	133,407		2,080						
b. RN									
1. Direct Care	1,389,963		29,625						
2. Administrative**	284,422		6,229						
c. LPN									
1. Direct Care	1,073,675		28,078						
2. Administrative**									
d. Aides and Attendants	2,526,739		111,924						
e. Physical Therapists	1,274,484		28,114						
f. Speech Therapists	137,448		2,590						
g. Occupational Therapists	433,266	(433,266)	9,664						
h. Recreation Workers	177,558		7,052						
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	252,236		6,395						
n. Marketing	65,141	(65,141)	2,462						
o. Other (Specify) See Attached Schedule	1,038,494	(992,129)	45,606						
<i>A-13. Total Salary Expenditures</i>	<i>11,537,239</i>	<i>(1,726,714)</i>	<i>377,159</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 in the Adjustment column.

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH / RHNS			(Specify)			(Specify)		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
Wages - Adm. Therapy Asst.	\$ 46,365		2,124						
Wages - Sports Adm. Assistant	\$ 97,982	\$ (97,982)	4,706						
Wages - Resident Services Coordinator	\$ 60,373	\$ (60,373)	2,056						
Wages - ALSA Dir.	\$ 83,753	\$ (83,753)	2,080						
Wages - ALSA RN	\$ 126,730	\$ (126,730)	2,980						
Wages - Personal Care Asst.	\$ 56,949	\$ (56,949)	2,694						
Wages - Support Serv. Supervisor	\$ 63,107	\$ (63,107)	2,120						
Wages - Support Services Asst.	\$ 119,157	\$ (119,157)	6,831						
Wages - Concierge Associate	\$ 51,606	\$ (51,606)	2,934						
Wages - CL Dietary	\$ 272,895	\$ (272,895)	15,187						
Wages - Director	\$ 20,520	\$ (20,520)	177						
Wages - Head Teacher	\$ 5,450	\$ (5,450)	201						
Wages - Teacher	\$ 18,071	\$ (18,071)	754						
Wages - Teacher Assistant	\$ 12,538	\$ (12,538)	616						
Wages - Adm. Assistant	\$ 2,998	\$ (2,998)	148						
Total	\$ 1,038,494	\$ (992,129)	45,606	\$ -	\$ -	-	\$ -	\$ -	-

Schedule of Other Fees (Page 13)

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

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		
Westview Nursing Care & Rehabilitation Center, Inc.			930-C	9/30/2023			11	37		
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	(Specify)	(Specify)							
Section I - Operators/Owners										
Herbert Czermak (10/1/22 to 9/30/23)	150,412			Non-Discriminatory	Comptroller	2,080	A1			
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).										
David T. Panteleakos (10/1/22 to 9/30/23)	220,833			Non-Discriminatory	Other Admin - Non-Nursing related	500	A2			

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

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

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page	of
Westview Nursing Care & Rehabilitation Center, Inc.				930-C		9/30/2023			12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	(Specify)	(Specify)							
Section III - Administrators***										
David T. Panteleakos (10/1/22 to 9/30/23)	108,049			Non-Discriminatory	Administrator	2,080	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.

Annual Report of Long-Term Care Facility

CSP-13 Rev. 3/2023

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of					
Westview Nursing Care & Rehabilitation Center, Inc	930-C	9/30/2023	13	37					
Total Cost and Hours									
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)									
1. Dietitian									
2. Dentist									
3. Pharmacist	1,500		4						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care									
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	65,000		410						
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) Medical Staff Fees	2,250		8						
9. Speech Therapist									
a. Resident Care									
b. Other									
10. Occupational Therapist									
a. Resident Care									
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	527		9						
2. Administrative***									
b. LPN									
1. Direct Care									
2. Administrative***									
c. Aides	4,452		117						
d. Other									
12. Other (Specify) See Attached Schedule									
B-13 Total Fees Paid in Lieu of Salaries	73,729		547						

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

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

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended					Page	of
Westview Nursing Care & Rehabilitation Center,	930-C	9/30/2023					15	37
Item	Total Including Adjustment	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
I. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	\$ 88,298	88,298						
2. Disability Insurance	\$							
3. Unemployment Insurance	\$ 83,660	83,660						
4. Social Security (F.I.C.A.)	\$ 846,319	846,319						
5. Health Insurance	\$ 612,248	612,248						
6. Life Insurance (employees only) (not-owners and not-operators)	\$ (1,945)	(1,945)						
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 270,225	270,225						
8. Uniform Allowance	\$							
9. Other (<i>Specify</i>) See Attached Schedule	\$ (158,726)	17,045	(175,771)					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)* Deferred Pension	\$ 1,000	1,000						
c. Bad Debts*	\$ (0)	27,477	(27,477)					
d. Accounting and Auditing	\$ 102,759	102,759						
e. Legal (<i>Services should be fully described on Page 15b</i>)	\$ 2,126	11,244	(9,118)					
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$	19,301	(19,301)					
g. Office Supplies	\$ 30,604	30,604						
h. Telephone and Cellular Phones								
1. Telephone & Pagers	\$ 6,551	6,551						
2. Cellular Phones	\$ 2,800	7,593	(4,793)					
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$							
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 159	159						
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	\$ 608,822	608,822						
Subtotal	\$ 2,494,898	2,731,358	(236,460)					

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Employee Physicals & Health	\$ 778					
Employee COVID Testing	\$ 1,700					
Background Checks	\$ 12,230					
Flex Spending Insurance	\$ 2,336					
Outpatient Therapy Fringe Disallowance		\$ (2,548)				
Marketing Salary Fringe Disallowance		\$ (10,817)				
OT Salary Fringe Disallowance		\$ (71,947)				
Assisted Living Fringe Disallowance		\$ (57,045)				
Child Day Care Fringe Disallowance		\$ (5,446)				
AL/CDC Pension/Health Disallowance		\$ (27,968)				
Total	\$ 17,045	\$ (175,771)	\$ -	\$ -	\$ -	\$ -

Schedule of Other Taxes

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

General Information and Questionnaire
Accounting Basis

Name of Facility Westview Nursing Care & Rehabil	License No. 930-C	Report for Year Ended 9/30/2023	Page 15b	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

- Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm 1 Marcum LLP 2 3 4	Address (No. & Street, City, State, Zip Code) 555 Long Wharf Dr. New Haven, CT 06511
--	---

Services Provided by This Firm (*describe fully*)

1 Annual financial audit and review; financial statements; annual corporate taxes, financial advisement	\$ 102,759
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 102,759

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

- Yes No

Legal Services Information

Name of Legal Firm or Independent Attorney 1 Wiggan & Dana 2 Northeastern Credit Services 3 4 5	Telephone Number 203-498-4400 860-871-2380
--	--

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

- 1 1 Century Tower, New Haven, CT
 2 117 Hartford Turnpike, Tolland, CT 06084
 3
 4
 5

Services Provided by This Firm (*describe fully*)

1 Collecting overdue patient balances	\$ 7,125
2 Court Fees	\$ 369
3 Probate Fees	\$ 3,525
4 DOL Audit	\$ 225
5	\$
	Charge for Services Provided
	\$ 11,244

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

- Yes No 15 1e

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

Name of Facility	License No.	Report for Year Ended				Page	of
Westview Nursing Care & Rehabilitation Center, Inc.	930-C	9/30/2023				16	37
Item	Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:	2,494,898	2,731,358	(236,460)				
l. Travel and Entertainment							
1. Resident Travel and Entertainment \$							
2. Holiday Parties for Staff \$	14,309	14,309					
3. Gifts to Staff and Residents \$	11,992	11,992					
4. Employee Travel \$	1,057	1,057					
5. Education Expenses Related to Seminars and Conventions \$	21,821	21,821					
6. Automobile Expense (<i>not purchase or depreciation</i>) \$	16,947	44,724	(27,777)				
7. Other (<i>Specify</i>) See Attached Schedule \$							
m. Other Administrative and General Expenses							
1. Advertising Help Wanted (<i>all such expenses</i>) \$	11,804	11,804					
2. Advertising Telephone Directory (<i>all such expenses</i>)*** \$							
3. Advertising Other (<i>Specify</i>)*** \$	(0)	58,937	(58,937)				
See Attached Schedule							
4. Fund-Raising*** \$							
5. Medical Records \$	5,900	4,673					
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)*** \$							
7. Postage \$	4,300	4,300					
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule \$	7,447	9,283					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.*** \$		400	(400)				
9. Subscriptions \$	5,302	5,302					
10. Contributions*** \$	(0)	6,863	(6,863)				
See Attached Schedule							
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>) \$	7,919	7,919					
12. Administrative Management Services** \$							
13. Other (<i>Specify</i>) \$	116,122	290,480	(174,358)				
See Attached Schedule							
C-14 Total Administrative & General Expenditures \$	2,719,818	3,224,613	(504,795)				

* Do not include Subscriptions, which should go in item 9.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
 *** Facility should self-disallow the expense in the Adjustment column.

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Promotional Advertising	\$ 58,937	\$ (58,937)				
Total Other Advertising	\$ 58,937	\$ (58,937)	\$ -	\$ -	\$ -	\$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
CAHCF	\$ 7,447					
Total Dues	\$ 7,447	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Donations Expense	\$ 6,863	\$ (6,863)				
Total Contributions	\$ 6,863	\$ (6,863)	\$ -	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
NP - Employee Discount	\$ 115					
Computer Operations Support	\$ 96,421					
Tuition Reimbursement	\$ 983	\$ (983)				
Business Expense - Owner	\$ 14,008	\$ (14,008)				
Bank Charges	\$ 16,769					
Misc. Expense - K.S.	\$ 152,198	\$ (152,198)				
A&G Supplies - COVID	\$ 328					
A&G Expenses - CLAWC	\$ 6,766	\$ (6,766)				
Licenses	\$ 2,490					
Fines & Penalties	\$ 403	\$ (403)				
Total Other Administrative and General	\$ 290,480	\$ (174,358)	\$ -	\$ -	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Westview Nursing Care & Rehabilitation	License No. 930-C	Report for Year Ended 9/30/2023	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #

* 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
Westview Nursing Care & Rehabilitation Center, Inc.		930-C	9/30/2023				18	37
Item	Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	\$ 381,423	387,642	(6,219)					
2. Non-Food Supplies	\$ 36,754	45,938	(9,184)					
3. Other (Specify) _____	\$							
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$							
c. Other (Specify) _____	\$							
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 418,177	433,580	(15,403)					
2E. Dietary Questionnaire		Total	CCNH / RHNS		(Specify)	(Specify)		
F. Resident Meals:	Total no. of meals served per day:*							
G. Is cost of employee meals included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No							
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 meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.			
K. Is any revenue collected 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)								
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.			
N. Is any revenue collected from employees?	<input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.			
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)								

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

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
Westview Nursing Care & Rehabilitation Center, Inc.		930-C	9/30/2023				19	37
Item		Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
3. Laundry								
a. In-House Processing*	Lbs.							
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	27,486	27,512	(26)				
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. \$	11,902	11,902					
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$							
c. Other (Specify)	\$							
3D. Total Laundry Expenditures (3a + b + c)	\$	39,388	39,414	(26)				
3E. Laundry Questionnaire								
F.	Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.				
G.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.				
H.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)						
I.	Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.				
J.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.				
K.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)						

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3D.

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

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

Name of Facility		License No.	Report for Year Ended				Page	of	
Westview Nursing Care & Rehabilitation Center		930-C	9/30/2023				20	37	
Item			Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4.	Housekeeping	Sq. Ft. Serviced by Personnel							
a.	In-House Care								
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt.	\$ 95,189	97,668	(2,479)				
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel							
		Amt.	\$						
	C. Other (<i>Specify</i>)		\$						
4D.	Total Housekeeping Expenditures (4a + b + c)		\$ 95,189	97,668	(2,479)				
5.	Resident Care (Supplies)**								
a.	Prescription Drugs***								
	1. Own Pharmacy		\$						
	2. Purchased from RX Health Pharmacy		\$ (0)	218,471	(218,471)				
b.	Medicine Cabinet Drugs		\$ 11,736	11,736					
c.	Medical and Therapeutic Supplies		\$ 210,002	223,250	(13,248)				
d.	Ambulance/Limousine***		\$						
e.	Oxygen								
	1. For Emergency Use		\$						
	2. Other***		\$	3,129	(3,129)				
f.	X-rays and Related Radiological Procedures***		\$ (0)	17,813	(17,813)				
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)		\$						
h.	Laboratory***		\$ (0)	26,612	(26,612)				
i.	Recreation		\$ 18,047	28,249	(10,202)				
j.	Direct Management Services*		\$						
k.	Indirect Management Services*		\$						
l.	Cable TV		\$ 7,200	16,500	(9,300)				
m.	Other (Specify)**** See Attached Schedule		\$ 0	22,054	(22,054)				
n.	Physical Therapy Expense		\$						
o.	Speech Therapy Expense		\$						
5P.	Total Resident Care Expenditures (5a - 5o)		\$ 246,985	567,813	(320,829)				

* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
 ** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.
 *** Facility should self-disallow the expense in the Adjustment column.
 **** ICFMR's should provide a detailed schedule of all Day Program Costs.

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

Name of Facility Westview Nursing Care & Rehabilitation Center, Inc.			License No. 930-C		Report for Year Ended 9/30/2023				Page of 21 37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH / RHNS	(Specify)	(Specify)	Pg	Line
Schindler Elevator Corp.	PO Box 93050 Chicago, IL	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Elevator Maintenance	31,533				
Willimantic Waste/Casella Waste	PO Box 239 Willimantic, CT	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Trash Removal & Compactor	31,761			22	6f
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
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		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

* 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
Westview Nursing Care & Rehabilitation Cent	930-C	9/30/2023				22	37
Item		Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)
6. Maintenance & Operation of Plant							
a. Repairs & Maintenance	\$	155,519	173,812	(18,293)			
b. Heat	\$	90,052	92,397	(2,345)			
c. Light & Power	\$	99,593	102,187	(2,594)			
d. Water	\$	38,969	39,984	(1,015)			
e. Equipment Lease (Provide detail on page 22b)	\$	77,506	77,506				
f. Other (itemize)	\$	113,198	116,146	(2,948)			
See Attached Schedule							
6g. Total Maint. & Operating Expense (6a - 6f)	\$	574,837	602,032	(27,195)			
7. Depreciation (complete schedule page 23*)							
a. Land Improvements	\$	53,307	53,307				
b. Building & Building Improvements	\$	264,978	264,978				
c. Non-Movable Equipment	\$	37,299	37,299				
d. Movable Equipment	\$	108,908	108,908				
*7e. Total Depreciation Costs (7a + b + c + d)	\$	464,492	464,492				
8. Amortization (Complete att. Schedule Page 24*)							
a. Organization Expense	\$						
b. Mortgage Expense	\$						
c. Leasehold Improvements	\$						
d. Other (Specify)	\$						
*8e. Total Amortization Costs (8a + b + c + d)	\$						
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	829,673	829,673				
10. Property Taxes							
a. Real estate taxes paid by owner	\$						
b. Real estate taxes paid by lessor	\$	110,274	113,146	(2,872)			
c. Personal property taxes	\$	4,642	4,642				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	1,409,081	1,411,953	(2,872)			

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

Schedule of Other Repairs and Maintenance

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Fuel - Gas	\$ 14,613					
Trash Removal	\$ 32,705					
Grounds Maintenance	\$ 37,752					
Security Expense	\$ 1,001					
Termite & Pest Control	\$ 1,589					
Plant Operations Purchased Services	\$ 12,629					
Minor Furnishings & Equipment	\$ 15,858					
Outpatient Allocation		\$ (2,948)				
Total Other Repairs and Maintenance	\$ 116,146	\$ (2,948)	\$ -	\$ -	\$ -	\$ -

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 Westview Nursing Care & Rehabilitation Center, Inc.			License No. 930-C		Report for Year Ended 9/30/2023		Page 22b	of 37	
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed		
	Yes	No							
Xerox Financial	<input type="radio"/>	<input checked="" type="radio"/>	Printers/Copiers	06/26/21	60 Months	77,506	77,506		
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes <input type="radio"/> No	Total ***	77,506

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

Depreciation Schedule

Name of Facility Westview Nursing Care & Rehabilitation Center, Inc.			License No. 930-C		Report for Year Ended 9/30/2023			Page 23	of 37				
Property Item			Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals			
A. Land Improvements													
1. Acquired prior to this report period			593,362		593,362	432,877	S/L	Various	53,307				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			15,350		15,350		S/L	Various	1,535				
A-4. Subtotal										54,842			
B. Building and Building Improvements													
1. Acquired prior to this report period			3,586,030		3,586,030	2,122,078	S/L	Various	264,978				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			489,213		489,213		S/L	Various	29,353				
B-4. Subtotal										294,331			
C. Non-Movable Equipment													
1. Acquired prior to this report period			781,645		781,645	596,051	S/L	Various	37,299				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			52,637		52,637		S/L	Various	5,264				
C-4. Subtotal										42,563			
		Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
		Yes	No	Month	Year								
D. Movable Equipment													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a. Plow Truck			X		11	2019	20,000	20,000	12,000	S/L	5	4,000	
b. Ford Truck			X		7	2022	61,724	61,724	12,345	S/L	5	12,345	
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period					Var	Var	1,882,797	1,882,797	1,752,713	S/L	Various	157,664	
b. Disposals (attach schedule)													
Acquired during this report period (attach schedule):													
c. Administrative					Var	Var	44,610	44,610		S/L	Various	5,799	
d. Standard Resident													
e. Specialized Resident													
Total Acquired during this report period							44,610	44,610				5,799	
D-3. Subtotal													179,808
E. Total Depreciation													571,544

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Var	See Attached	\$ 15,350	Var	\$ 1,535
Total additions for Land Improvements		\$ 15,350		\$ 1,535 *
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:				
Var	See Attached	\$ 489,213	Var	\$ 29,353
Total additions for Building Improvements		\$ 489,213		\$ 29,353 *
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:				
Var	See Attached	\$ 52,637	Var	\$ 5,264
Total additions for Non-Movable Equipment		\$ 52,637		\$ 5,264 *
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
Additions:					
Var	See Attached	Administrative	\$ 44,610	Var	\$ 5,799
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
Total additions for Movable Equipment			\$ 44,610		\$ 5,799 *
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:				
Total additions for Leasehold Improvement		\$ -		\$ - *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility

Amortization Schedule*

Name of Facility			License No.		Report for Year Ended			Page	of
Westview Nursing Care & Rehabilitation Center, Inc.			930-C		9/30/2023			24	37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
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	Var	Var		385,223	348,070	S/L	Var	8,426	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									8,426
D. Total Amortization									8,426

* 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 Westview Nursing Care & Rehabilitation	License No. 930-C	Report for Year Ended 9/30/2023	Page 25	of 37
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11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?*

Yes No

If "Yes," complete Part B.
If "No," complete Part C.

*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total			
1. Date Land Purchased	08/07/74			
2. Date Structure Completed	01/01/54			
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure	08/07/74			
5. Total Licensed Bed Capacity	103			
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)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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
Westview Nursing Care & Rehabilita		930-C	9/30/2023				26	37
Item		Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
12. Interest								
A. Building, Land Improvement & Non-Movable Equipment								
1. First Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
2. Second Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
3. Third Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
4. Fourth Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
B. CHEFA Loan Information								
1. Original Loan Amount		\$						
2. Loan Origination Date								
3. Interest Rate %								
4. Term								
5. CHEFA Interest Expense								
12 B7. 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
Westview Nursing Care & Rehabil		930-C		9/30/2023				27	37
Item				Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(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)				\$					
Interest Expense - FME					(671)	671			
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$					
					(671)	671			
14. Insurance									
a. Insurance on Property (buildings only)				\$	128,894	132,251	(3,357)		
b. Insurance on Automobiles				\$	(624)	(624)			
c. Insurance other than Property (as specified above)									
1. Umbrella (Blanket Coverage)				\$					
2. Fire and Extended Coverage				\$					
3. Other (Specify)				\$					
14d. Total Insurance Expenditures (14a + b + c)				\$	128,270	131,627	(3,357)		
15. Total All Expenditures (A-13 thru C-14)				\$	15,515,999	18,118,997	(2,602,999)		

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Westview Nursing Care & Rehabilitation	930-C	9/30/2023		30	37
Item	Total	CCNH / RHNS	(Specify)	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 6,223,902	6,223,902			
b. Medicaid Room and Board Contractual Allowance **	\$ (1,179,682)	(1,179,682)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 2,959,659	2,959,659			
b. Medicare Room and Board Contractual Allowance **	\$ 1,560,114	1,560,114			
4. a. Private-Pay Residents and Other	\$ 4,556,066	4,556,066			
b. Private-Pay Room and Board Contractual Allowance **	\$ 18,208	18,208			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 332,692	332,692			
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$ 1,075	1,075			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$				
2. a. Medical Supplies - Medicare	\$ 26,105	26,105			
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$ 67,441	67,441			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$ 1,833,853	1,833,853			
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$ 21,767	21,767			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$ 449,451	449,451			
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$ 1,901,564	1,901,564			
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$ 21,988	21,988			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other (<i>Specify</i>) - Medicare	\$ (3,802,843)	(3,802,843)			
b. Other (<i>Specify</i>) - Non-Medicare	\$ 1,997,594	1,997,594			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 16,988,955	16,988,955			
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$ 4,558	4,558			
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$ 40,868	40,868			
6. Private Duty Nurses' Fees	\$ 157	157			
7. Barber, Coffee, Beauty and Gift shops	\$ 479	479			
8. Other (<i>Specify</i>)	\$ 3,418,084	3,418,084			
V. Total Other Revenue (1 thru 8)	\$ 3,464,146	3,464,146			
VI. Total All Revenue (III +V)	\$ 20,453,101	20,453,101			

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
30 II 6a	Medicare A - IV Therapy	\$ 19,257		
30 II 6a	Medicare A - X-Ray	\$ 19,035		
30 II 6a	Medicare Advantage - X-Ray	\$ 4,936		
30 II 6a	Medicare Advantage - IV Therapy	\$ 1,514		
30 II 6a	Medicare B - Vaccines	\$ 22,371		
30 II 6a	Medicare B - Contractual Adjustment	\$ (1,008,655)		
30 II 6a	Medicare B - Sequestration Adjustment	\$ (8,047)		
30 II 6a	Medicare Advantage - Contractual Anc.	\$ (566,922)		
30 II 6a	Medicare A - Contractual Ancillaries	\$ (2,286,332)		
Total Other Resident Revenue - Medicare		\$ (3,802,843)	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
30 II 6b	Private - Contracted Services CLAWC	\$ 710,000		
30 II 6b	Private - Contracted Services Child Care Center	\$ 64,063		
30 II 6b	Medicaid - IV Therapy	\$ 897		
30 II 6b	Contract/WComp - X-Ray	\$ 664		
30 II 6b	Managed Care B - Vaccines	\$ 6,407		
30 II 6b	Outpatient - Part B Revenue	\$ 930,014		
30 II 6b	Outpatient - Part B Sequestration	\$ (4,445)		
30 II 6b	Outpatient - Part B Adjustment	\$ (647,308)		
30 II 6b	Outpatient - Insurance Revenue	\$ 3,584,213		
30 II 6b	Outpatient - Insurance Adjustment	\$ (2,615,214)		
30 II 6b	Outpatient - Private Revenue	\$ 2,227		
30 II 6b	Outpatient - Private Adjustment	\$ (352)		
30 II 6b	Outpatient Other Contractual Allow	\$ (3,440)		
30 II 6b	Nurse Practitioner - Employee Health	\$ 10,625		
30 II 6b	Nurse Practitioner - Emp. Discounts	\$ (11,950)		
30 II 6b	Nurse Practitioner CA - IP	\$ (43,901)		
30 II 6b	Nurse Practitioner CA - OP	\$ (14,385)		
30 II 6b	Nurse Practitioner IP Revenue	\$ 73,139		
30 II 6b	Nurse Practitioner OP Revenue	\$ 26,847		
30 II 6b	Massage Therapy Revenue	\$ 40,983		
30 II 6b	Athletic Training Revenue	\$ 150,645		
30 II 6b	Managed Care B - Contractual Adjustment	\$ (161,319)		
30 II 6b	Managed Care B - Sequestration	\$ (770)		
30 II 6b	Contract/WComp - Contractual Anc.	\$ (35,293)		
30 II 6b	Medicaid - Contractual Ancillaries	\$ (64,751)		
Total Other Resident Revenue		\$ 1,997,594	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	(Specify)
30 IV5	Interest Income	N/A	\$ 40,868		
Total Interest Income			\$ 40,868	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
30 IV 8	Misc. Income	\$ 3,215,484		
30 IV 8	Small Balance Adjustments	\$ (546)		
30 IV 8	Medical Record Copies	\$ 694		
30 IV 8	Legal/Other Fees	\$ (448)		
30 IV 8	Misc. Income	\$ 202,800		
30 IV 8	Charitable Donations	\$ 100		
Total Other Revenue		\$ 3,418,084	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Westview Nursing Care & Rehabilitatio	930-C	9/30/2023	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	2,751,900
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,073,492
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	216,219
4. Inventories			\$	12,432
5. Prepaid Expenses			\$	192,960
a. Insurance	192,960			
b. _____				
c. _____				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	4,247,003
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	608,712	\$	120,993
	Accum. Depreciation	487,719	Net	
3. Buildings	*Historical Cost	4,075,243	\$	1,658,834
	Accum. Depreciation	2,416,409	Net	
4. Leasehold Improvements	*Historical Cost	385,223	\$	28,727
	Accum. Depreciation	356,496	Net	
5. Non-Movable Equipment	*Historical Cost	834,282	\$	195,668
	Accum. Depreciation	638,614	Net	
6. Movable Equipment	*Historical Cost	1,927,407	\$	11,231
	Accum. Depreciation	1,916,176	Net	
7. Motor Vehicles	*Historical Cost	81,724	\$	41,034
	Accum. Depreciation	40,690	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	372,805
Book vs Cost Report		372,805		
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	2,429,292

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			\$ -

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

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

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

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

Page Ref	Line Ref	Description	
33	A12	Deferred Tax Liability	\$ (37,541)
33	A12	Garnishments	\$ 290
33	A12	FICA	\$ 38,915
33	A12	Workers Comp	\$ 100,201
33	A12	State Withholding - CT	\$ 11,136
33	A12	Federal Withholding	\$ 30,608
Total Other Current Liabilities (Itemize)			\$ 143,608

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

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Westview Nursing Care & Rehabilitatio	930-C	9/30/2023	32	37
Account			Amount	
Total Brought Forward:			\$	6,676,295
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	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	7,137,444
Name and Address	Amount	Loan Date		
Due To/From Landlord, Country Living, CLAWC, Daview, Westview Villa, Child Care Center	7,137,444	Var		
7. Other Assets (<i>itemize</i>)			\$	

See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	7,137,444
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	13,813,740

* 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
Westview Nursing Care & Rehabilitation Cent		930-C	9/30/2023	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	249,132
2. Notes Payable (<i>itemize</i>)				\$	

See Schedule					
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	648,793
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	20,638
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>)				\$	485,081
State Unemployment - CT		7,530 Resident Trust	47,897		
State FMLA - CT		14,454 Resident Recreation Func	9,777		
Deferred Revenue		111,231 Provider Tax Liability	158,772		
Resident Refunds		(8,188) See Schedule	143,608		
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	1,403,644

* 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 Westview Nursing Care & Rehabilitation C	License No. 930-C	Report for Year Ended 9/30/2023		Page 34	of 37
Account				Amount	
Total Brought Forward:				1,403,644	
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>)				\$	

See Schedule					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 1,403,644	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Westview Nursing Care & Rehabilitat	930-C	9/30/2023	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<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			\$	
2. Capital Stock			\$	4,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	10,071,991
6. Gain or Loss for Period			\$	2,334,103
	10/1/2022	thru	9/30/2023	
7. Total Net Worth			\$	12,410,095
C. Total Reserves and Net Worth			\$	12,410,095
D. Total Liabilities, Reserves, and Net Worth			\$	13,813,739

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Westview Nursing Care & Rehabilitation	930-C	9/30/2023	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2022			\$	8,369,493
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	20,453,101
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	18,118,998
D. Net Income or Deficit			\$	2,334,103
E. Balance			\$	10,703,596
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			\$	10,703,596
				09/30/23

I. Preparer's/Reviewer's Certification

Name of Facility Westview Nursing Care & Rehabilitation	License No. 930-C	Report for Year Ended 9/30/2023	Page 37	of 37
<i>Check appropriate category</i>				
Chronic and Convalescent Nursing <input checked="" type="checkbox"/> Home (CCNH) & RHNS Combined	<input type="checkbox"/> (Specify)	<input type="checkbox"/> (Specify)		
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				
Janessa Choquette				
Address Address		Phone Number		
150 Ware Rd., Dayville, CT 06241		860-774-8574		
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number		
Janessa Choquette		860-774-8574		
Contact Email Address				
jchoquette@westviewhcc.com				