State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2017

Name of Facility (as licensed) Willows Care and Rehabilitation Center		
Address (No. & Street, City, State, Zip Code) 225 Amity Road, Woodbridge, CT 06525		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2202-C			07-5331

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	220559		

For Department Use Only

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

Table of Contents

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Willows Care and Rehabilitation Center [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)	Date	Signed (Owner)	Date
		[signature]	11/6/2017
Printed Name (Administrator) Peter Mongillo		Printed Name (Owner) Keith Davis, V.P. of Reimb., Genesis Healthcare	

Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires
Gretchen A. Jeannette	PA	11-6-17	Gretchen A. Jeannette	09/23/21

Address of Notary Public 101 E. State St.
Kennett Square, PA 19348

(Notary Seal)

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
Gretchen A. Jeannette, Notary Public
Kennett Square Boro, Chester County
My Commission Expires Sept. 23, 2021
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1A Rev. 6/95

State of Connecticut
Department of Social Services
25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Willows Care and Rehabilitation Center	Period Covered:		From 10/1/2016	To 9/30/2017
Address of Facility 225 Amity Road, Woodbridge, CT 06525				
Report Prepared By Thomas Farnan	Phone Number 978-247-5029		Date 12/21/2017	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$	278,006	278,006		
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$	3,485,364	3,485,364		
5. All other wages paid	$	581,834	581,834		
6. ***Total Wages Paid***	$	4,345,203	4,345,203		
7. Total salaries paid	$	217,607	217,607		
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$	4,562,810	4,562,810		

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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-2 Rev. 10/2005

General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-387-0076	9/30/2017	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Willows Care and Rehabilitation Center	225 Amity Road, Woodbridge, CT 06525

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2202-C			07-5331

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Type of Ownership (Check appropriate box)

○ Proprietorship ◉ LLC ○ Partnership ○ Profit Corp. ○ Non-Profit Corp. ○ Government ○ Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Peter Mongillo	1401/1860

Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name	License No.:

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3 Rev. 10/2005

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned
Harborside Health I Corporatic	101 Sun Ave. NE, Albuquerque, NM 87109		1
Harborside Healthcare Limited	101 Sun Ave. NE, Albuquerque, NM 87109		99

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3A Rev. 10/2005

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	3A	37

If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Willows Care and Rehabilitation Center	101 East State Street, Kennett Square, PA 19348	PA

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
N/A			
Names of Stockholders Owning at Least 10% of Shares			
N/A			

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3B Rev. 10/2005

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	3B	37

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

Owner(s) of Facility

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-4 Rev. 10/2005

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	4	37

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Genesis Health Ventures	101 East State Street, Kennett Square, PA 19348	⊙	○		Home Office	Pg 16/m12	427,761	427,761
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	⊙	○	63%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	1,186,479	1,186,479
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	○	⊙		Staffing Pool	Pg 10/A12	25,083	25,083
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	⊙	○	83%	Medical Director /NP	Pg 13/B8, Pg 10/A12	43,900	43,900
Career Staffing	101 East State Street, Kennett Square, PA 19348	⊙	○	60%	Outside Agency	Pg 13/B11 a,b,c		
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	⊙	○	44%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E	26,303	26,303
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	⊙	○		Insurance	Pg 27/14	148,550	148,550
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	⊙	○		Capital Interest	Page 17, page 26-12A	34,123	34,123
		○	○					

* Use additional sheets if necessary.

** Provide the percentage amount of revenue received from non-related parties.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-5 Rev. 9/2002

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	5	37

If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-6 Rev. 9/2002

General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
						Total ***	

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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-7 Rev. 6/95

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Ce	2202-C	9/30/2017	7	37

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 KPMG Peat Marwick	1600 Market Street, Philadelphia, PA 19103
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Year end financial audit	$
2		$
3		$
4		$

Charge for Services Provided $

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	Telephone Number
1 Goldman Gruder & Woods LLC	(203) 899-8900
2 Timothy S. Wall State Marshal and CT Probate Court	
3	
4	
5	

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

1 200 Connecticut Ave, Norwalk, CT 06854
2 P.O Box 297 Wallingford, CT 06492
3
4
5

Services Provided by This Firm (*describe fully*)

1	Reduction in R.E tax Assesstment	$ 3,500
2	Marshall Fee and Probate Court fee for the Conservatorship	$ 646
3		$
4		$
5		$

Charge for Services Provided $ 4,146

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

⊙ Yes ○ No Legal Fees pg. 15 1-e

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 9/2002

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	90	90			90	90			90	90		
B. On last day of THIS report period	90	90			90	90			90	90		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	81	81			81	81			81	81		
B. As of midnight of THIS report period	85	85			81	81			85	85		
3. Total Number of Days Care Provided During Period												
A. Medicare	7,057	7,057			5,692	5,692			1,365	1,365		
B. Medicaid (Conn.)	16,732	16,732			12,300	12,300			4,432	4,432		
C. Medicaid (other states)												
D. Private Pay	1,451	1,451			1,069	1,069			382	382		
E. State SSI for RCH												
F. Other (Specify)	4,431	4,431			3,071	3,071			1,360	1,360		
G. Total Care Days During Period (3A thru F)	29,671	29,671			22,132	22,132			7,539	7,539		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	41	41			34	34			7	7		
B. Other Bed Reserve Days	7	7			3	3			4	4		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	29,719	29,719			22,169	22,169			7,550	7,550		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	9	37

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

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(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)
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	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-IID
No. of Residents	17	47		21				
Per Diem Rate								
a. One bed rm.								
b. Two bed rms.	626.75	241.73		519.18				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	1,589	1,589		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	169	169		
C. Other	28,702	28,702		
D. ***Total Physical Therapy Treatments***	30,460	30,460		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	183	183		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	40	40		
C. Other	1,121	1,121		
D. ***Total Speech Therapy Treatments***	1,344	1,344		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,837	1,837		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	230	230		
C. Other	28,898	28,898		
D. ***Total Occupational Therapy Treatments***	30,965	30,965		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	10	37

Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ 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)	115,043	2,086				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	169,004	7,974				
5. Dietary Service						
a. Head Dietitian	12,741	405				
b. Food Service Supervisor	37,590	1,397				
c. Dietary Workers	227,675	12,702				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	67,508	2,109				
b. Other Maintenance Workers	29,491	1,633				
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	102,564	2,092				
b. RN						
1. Direct Care	1,062,118	27,240				
2. Administrative**	94,587	2,300				
c. LPN						
1. Direct Care	864,993	27,501				
2. Administrative**						
d. Aides and Attendants	1,381,819	71,059				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	130,711	5,267				
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	185,120	6,828				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	81,846	3,964				
A-13. Total Salary Expenditures	4,562,810	174,557				

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

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

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

Schedule of Other Salaries and Wages (Page 10)

		CCNH		RHNS		(Specify)	
Position		**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Ward Clerks	0	0	0			0	0
Coordinator-Staffing Centers	0	51299	2519			0	0
Central Supply	0	2053	118			0	0
Medical Records	0	28494	1327			0	0
0	0	0	0				
0	0	0	0				
0	0	0	0				
0	0	0	0				
0	0	0	0				
0	0	0	0				
0	0	0	0				
0	0	0	0				
0	0	0	0				
0	0	0	0				
0	0	0	0				
Total		81846	3964	$ -	-	$ -	-
		0	0				

Schedule of Other Fees (Page 13)

		CCNH		RHNS		(Specify)	
Service		**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
3155620020	Purchased Services	(42.58)	n/a			-	
3155620020	Purchased Services	2,726.75	n/a				
1020620010	Consulting Fees	480.52	n/a				
1020620010	Consulting Fees	213.11	n/a				
0	0	-	n/a				
0	0	-	n/a				
0	0	-	-				
0							
0							
0							
Total		3378	0	$ -	-	$ -	-
		0					

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-11 Rev. 10/2005

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
Willows Care and Rehabilitation Center	2202-C	9/30/2017	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-12 Rev. 10/2005

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
Willows Care and Rehabilitation Center	2202-C	9/30/2017	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)							
Section III - Administrators* **										
Peter Mongillo	115,043				Management of Center	2,086	2			
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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	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						
2. Dentist	10,337	71				
3. Pharmacist	7,773	159				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	1,107,352	15,169				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	68,150	361				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	20,173	259				
b. Other						
10. Occupational Therapist						
a. Resident Care	61,458	842				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care	138	2				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	3,378					
B-13 Total Fees Paid in Lieu of Salaries	1,278,760	16,862				

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-14 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
		⊙	○	
Genesis Eldercare Rehabilitation Services, 101 East State Street, Kennett Square, PA 19348	Physical, Occupational, and Speech Therapy	⊙	○	Common Ownership
Genesis Eldercare Physician Services, 101 East State Street, Kennett Square, PA 19348	Medical Director	⊙	○	Common Ownership
Genesis Eldercare Staffing Services, 101 East State Street, Kennett Square, PA 19348	Nursing Pool	⊙	○	Common Ownership
Respiratory Health Services, 515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	Respiratory and Oxygen Supplies	⊙	○	Common Ownership
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
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		○	○	
		○	○	
		○	○	
		○	○	

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	232,766	232,766		
2. Disability Insurance	$				
3. Unemployment Insurance	$	58,657	58,657		
4. Social Security (F.I.C.A.)	$	340,197	340,197		
5. Health Insurance	$	229,580	229,580		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$				
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	317,850	317,850		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and	$				
Profit Sharing Plans for Owners and					
Operators (Discriminatory)*					
c. Bad Debts*	$	11,499	11,499		
d. Accounting and Auditing	$				
e. Legal (*Services should be fully described on Page 7)*	$	4,146	4,146		
f. Insurance on Lives of Owners and	$				
Operators (*Specify*)*					
g. Office Supplies	$	26,085	26,085		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	23,012	23,012		
2. Cellular Phones	$	612	612		
i. Appraisal (*Specify purpose and*	$				
attach copy)*					
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$	(144)	(144)		
See Attached Schedule					
3. Resident Day User Fee	$	404,552	404,552		
Subtotal	$	1,648,812	1,648,812		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description		CCNH	RHNS	(Specify)
3030520020	Union Health & Welfare	40,980.00	0	
3040520020	Union Health & Welfare	750.00	0	
3225520020	Union Health & Welfare	267,165.00	0	
5035520020	Union Health & Welfare	8,955.00	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
Total		$ 317,850	$ -	$ -

0

Schedule of Other Taxes

Description		CCNH	RHNS	(Specify)
1020640110	Sales Tax	(382.00)	0	0
1020640110	Sales Tax	238.00	0	0
1020640110	Sales Tax	-	0	0
0	0	-		
Total		$ (144)	$ -	$ -

0

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,648,812	1,648,812		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	809	809		
5. Education Expenses Related to Seminars and Conventions	$	1,302	1,302		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$				
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	11,028	11,028		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$	0	0		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	3,556	3,556		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	8,268	8,268		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	400	400		
10. Contributions***	$	1,237	1,237		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	3,782	3,782		
12. Administrative Management Services**	$	468,722	468,722		
13. Other (*Specify*)	$	28,692	28,692		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,176,607	2,176,607		

* 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)
				0
				0
				0
				0
				0
				0
Total Other Travel and Entertainment		$ -	$ -	$ -

Schedule of Other Advertising

Description		CCNH	RHNS	(Specify)
1020630330	Marketing Expense	5779.91	0	0
1020630330	Marketing Expense	70.65	0	0
1020630020	Advertising	371.37	0	0
1020630020	Advertising	1400.92	0	0
3165630330	Marketing Expense	63.69	0	0
1020630330	Marketing Expense	68.99	0	0
1020630331	Marketing Exp- Corpor	456.91	0	0
1020630331	Marketing Exp- Corpor	2815.79	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
Total Other Advertising		$ 11,028	$ -	$ -
		$ -		

Schedule of Dues

Description		CCNH	RHNS	(Specify)
1020630310	License Fees	8268.42	0	0
1020630310	0	0	0	0
1020630310	0	0	0	0
1020630310	0	0	0	0
1020630310	0	0	0	0
1020630310	0	0	0	0
1020630310	0	0	0	0
1020630310	0	0	0	0
1020630310	0	0	0	0
1020630310	0	0	0	0
			0	0
			0	0
			0	0
Total Dues		$ 8,268	$ -	$ -
		$ -		

Schedule of Contributions

Description	CCNH	RHNS	(Specify)

1020630130	Contributions	1236.68	0	0
1020630135	Political Contributions	0	0	0
0	0	0	0	0
Total Contributions		$ 1,237	$ -	$ -
		$ -		

Schedule of Other Administrative and General

Description		**CCNH**	**RHNS**	**(Specify)**
1020630120	Collection Fees	459.8	0	0
1020630120	Collection Fees	115.36	self-disallowed	0
1020630120	Collection Fees	-1187.92	self-disallowed	0
3165630140	Education Expense	199.99	0	0
1020630060	Bank Service Charges	11010.83	0	0
1020630140	Education Expense	133.02	0	0
1020630140	Education Expense	18.1	0	0
1020630180	Employee Physicals	8638.24	0	0
1020630200	Employee Relations	4719.31	0	0
3165630310	Licenses & Certificatio	199.99	0	0
1020630380	Printing	158.43	0	0
1020630610	Training Expense	148.34	0	0
1020630610	Training Expense	532.88	0	0
1020640090	Miscellaneous	151.58	0	0
1020640090	Miscellaneous	-0.74	0	0
1020660080	Rental Expense	10.68	0	0
1020660990	Accrued Expense Estin	499.27	self-disallowed	0
1020720070	State Tax Annual Repo	485	0	0
5095720090	Landlord Operating Ta	2400	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
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0	0	0	0	0
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0	0	0	0	0
0	0	0	0	0
Total Other Administrative and General		$ 28,692	$ -	$ -
		0		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2017	Page 17 | of 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 #
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	427,761	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	34,123	Capital Interest	pg 26 12-A-1

*** 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.**

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-18 Rev. 9/2002

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
Willows Care and Rehabilitation Center	2202-C	9/30/2017	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	135,495	135,495		
2. Non-Food Supplies	$	18,643	18,643		
3. Other (*Specify*)_____	$	(1,616)	(1,616)		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	146,637	146,637		
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	299,159	299,159		

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

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-19 Rev. 9/2002

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

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2017		Page 19 | of 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. $	6,766	6,766		
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. $	8,739	8,739		
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)* — $	151,220	151,220		
c. Management Services** — $				
d. Other (*Specify*) — $				
3E. ***Total Laundry Expenditures*** (3a + b + c + d) — $	166,725	166,725		

3F.	Laundry Questionnaire			
G.	Is cost of employee laundry included in 3E?	○ Yes	⊙ No	If yes, specify cost.
H.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report?			(Page/Line Item)
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	○ Yes	⊙ No	If yes, specify cost.
K.	Did you receive revenue from these people?	○ Yes	⊙ 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-20 Rev. 9/2002

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
Willows Care and Rehabilitation Center	2202-C	9/30/2017	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	11,614	11,614		
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$	227,608	227,608		
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	239,222	239,222		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	388,599	388,599		
b. Medicine Cabinet Drugs		$	25,384	25,384		
c. Medical and Therapeutic Supplies		$	127,528	127,528		
d. Ambulance/Limousine***		$	9,333	9,333		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	13,518	13,518		
f. X-rays and Related Radiological Procedures***		$	20,527	20,527		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	45,211	45,211		
i. Recreation		$	25,374	25,374		
j. Other (Specify)**** See Attached Schedule		$	70,688	70,688		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	726,162	726,162		

* 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)
3060610160	Incontinency	30922.03	0	0
3080630030	Advertising-Help Wan	203.73	0	0
3080630030	Advertising-Help Wan	753.81	0	0
3080630080	Books, Dues & Subsc	160.98	0	0
3080630140	Education Expense	1592.69	0	0
3080630140	Education Expense	675.88	0	0
3120630530	Supplies	2359.41	0	0
3155630530	Supplies	4841.51	0	0
3155630530	Supplies	5239.52	0	0
3120660080	Rental Expense	140.93	0	0
3155660080	Rental Expense	59.67	0	0
3155660080	Rental Expense	6785	0	0
3010610300	Consolidated Billing	16953.2	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
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Total Other Resident Care		$ 70,688	$ -	$ -
		0		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 10/2001

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

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	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)	Pg	Line
Healthcare Services Group	Drive, Bensalem, PA 19020	○	⊙	Vendor Contracted	Laundry Purchased Services	151,220			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	○	⊙	Vendor Contracted	Housekeeping Purchased Services	226,351			20	4b
Healthcare Services Group	Drive, Bensalem, PA 19020	○	⊙	Vendor Contracted	Dietary Purchased Servies	146,923			18	2b
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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).

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended			Page of
Willows Care and Rehabilitation Center	2202-C	9/30/2017			22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	207,742	207,742		
b. Heat	$	52,629	52,629		
c. Light & Power	$	142,101	142,101		
d. Water	$	38,225	38,225		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$				
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	440,697	440,697		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	5,782	5,782		
b. Building & Building Improvements	$	14,811	14,811		
c. Non-Movable Equipment	$	26,342	26,342		
d. Movable Equipment	$	26,267	26,267		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	73,201	73,201		
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	$	1,443,427	1,443,427		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	256,201	256,201		
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,772,829	1,772,829		

* 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)
Total Other Repairs and Maintenance	$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-23 Rev. 10/2006

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	57,818		57,818	4,336	S/L	Various	5,782	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	925		925					
A-4. Subtotal								5,782
B. **Building and Building Improvements**								
1. Acquired prior to this report period	154,544		154,544	15,810	S/L	Various	14,361	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	27,511		27,511				450	
B-4. Subtotal								14,811
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	233,610		233,610	80,219	S/L	Various	25,374	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	28,055		28,055				969	
C-4. Subtotal								26,342

	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.									S/L	Various		
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					212,301		212,301	104,930	S/L	Various	25,931	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					7,122		7,122				336	
D-3. Subtotal												26,267
E. ***Total Depreciation***												73,202

Willows Care and Rehabilitation Center
9/30/2017

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
9/30/2017	Sept Accrual	925.00		
Total additions for Land Improvements		925		-
Deletions:		0		0
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:				
11/30/2016	Architectural Services	1,075.00	20.00	44.79
1/31/2017	Deposit for installation of fire doors	2,604.87	20.00	86.83
3/31/2017	Daikin water source heat pump final pay	2,250.00	20.00	56.25
3/31/2017	Electronic Lock,Satin Chrome,12 Butto	651.34	20.00	16.28
3/31/2017	Daikin water source heat pump 1st pay	2,250.00	20.00	56.25
6/30/2017	Sprinkler System	13,470.29	20.00	168.38
8/31/2017	4-fire doors interior	5,209.72	20.00	21.71
Total additions for Building Improvements		$ 27,511		$ 450

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:				
3/31/2017	Bradford White water heater	5,140.00	10	257.00
5/31/2017	1st install payment on cooler/freezer	16,635.00	10	554.50
6/30/2017	Hot Water Heater	6,280.00	10	157.00
				-
				-
				-
				-
Total additions for Non-Movable Equipment		$ 28,055		$ 969
Deletions:				
Total deletions for Non-Movable Equipment		$ -		$ -
***Ties to Page 23, Line C3**		0.00		$ -

****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:				
11/30/2016	Panacea Fixed Frame Wheelchair	241.98	10.00	20.17
12/31/2016	Direct Choice Basic Wheelchair	269.98	10.00	20.25

12/31/2016	Direct Choice Basic Wheelchair	267.98	10.00	20.10
1/31/2017	Panacea Transport Wheelchair,	223.98	10.00	14.93
1/31/2017	Direct Choice Overbed Table	446.54	10.00	29.77
1/31/2017	Direct Choice Overbed Table	447.81	10.00	29.85
2/28/2017	2 Direct Choice Basic Wheelchair	271.98	10.00	15.87
2/28/2017	Panacea Transport Wheelchair,	111.99	10.00	6.53
2/28/2017	6 Direct Choice Overbed Table	446.54	10.00	26.05
3/31/2017	Medium Duty Manual 12i Slicer	1,633.51	10.00	81.68
4/30/2017	GE Refrigerator, 14.6 Cu Ft	644.47	10.00	26.85
9/30/2017	Food Processor w/ Continuous Feed	1,297.63	7.00	-
7/31/2017	Panacea Foam Mattress	328.71	3.00	18.26
8/31/2017	Panacea Flip Foam Mattress, 35	306.51	3.00	8.51
10/31/2016	Logan Office Chair	182.77	10.00	16.75
Total additions for Movable Equipment		$ 7,122		$ 336
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**

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State of Connecticut
Annual Report of Long-Term Care Facility
CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-25 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Cente	2202-C	9/30/2017	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ○ Yes ⊙ No

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	90
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
SABRA, 101 Sun Ave. NE, Albuquerque, NM 87109	Facility Lease	11/15/10 - 6/30	127 months	1,443,427

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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-26 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Willows Care and Rehabilitation Cen	2202-C	9/30/2017	26 | 37

Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$	34,123	34,123		
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)	$	34,123	34,123		

(*Carry Subtotals forward to next page*)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-27 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Willows Care and Rehabilitation Ce	2202-C	9/30/2017	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	34,123	34,123		
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*) $				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	34,123	34,123		
14. Insurance				
a. Insurance on Property (buildings only) $	3,531	3,531		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	145,018	145,018		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	148,549	148,549		
15. ***Total All Expenditures (A-13 thru C-14)*** $	11,845,643	11,845,643		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-28 Rev. 9/2002

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	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 $	248	248		
Page 13 - Professional Fees							
5.	13	B-8-c	Resident Care Physicians ** $				
6.		B-10	Occupational Therapy $				
7.			Other - See attached Schedule $	1,191,668	1,191,668		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1-c	Bad Debts $	11,499	11,499		
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.	16	m-2 &	Unallowable Advertising * $	11,028	11,028		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $	1,237	1,237		
21.			Unallowable Management Fees $	502,845	502,845		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	78,233	78,233		
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) $	1,796,758	1,796,758		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
10	2	Administrator's salary disallowed	0	248	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
Total Other Salaries Adjustment				$ 248	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	3120620020	59698.15	0	0
13	5	Rehabilitation Services	3195620020	1047654.32	0	0
13	9	Speech Therapist	3170620020	20173.11	0	0
13	10	Occupational Therapist	3105620020	61458.09	0	0
13	12	Other	3010620020	0	0	0
13	12	Other	3015620020	0	0	0
13	12	Respiratory Purchased Servies	3155620020	2684.17	0	0
					0	0
					0	0
					0	0
					0	0
					0	0
Total Other Fees Adjustments				$ 1,191,668	$ -	$ -
				$ -		

Schedule of Other A&G Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
16	m-13	Collection Fees	1020630120	(612.76)	0	0
16	m-8a	Chamber of Commerce	1020630310	-	0	0
16	m-13	Estimated Accrual	1020660990	499.27	0	0
16	m-13	Fines & Penalties	1020640080	-	0	0
16	m-13	Non-recurring Charges	7010800030	-	0	0
16	m12	0	0	-	0	0
15	1-a-1	adj workers comp	0	78,346.73	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
Total Other A&G Adjustments				$ 78,233	$ -	$ -
				0		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-29 Rev. 10/2006

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

Name of Facility	License No.	Report for Year Ended	Page of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	1,796,758	1,796,758		
Page 20 - Resident Care Supplies***							
27.	20	5-a-2	Prescription Drugs $	388,599	388,599		
28.	20	5-d	Ambulance/Limousine $	9,333	9,333		
29.	20	5-f	X-rays, etc $	20,527	20,527		
30.	20	5-h	Laboratory $	45,211	45,211		
31.			Medical Supplies $				
32.	20	5-e-2	Oxygen (non emergency) $	13,518	13,518		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	46,512	46,512		
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 $	(54,831)	(54,831)		
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)*** $	2,265,628	2,265,628		

*** 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.

Willows Care and Rehabilitation Center
9/30/2017

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-j	Consolidated Billing	16953.2	3010610300	0
20	5-j	Respiratory Supplies	10081.03	3155630530	0
20	5-j	Respiratory Rental	6844.67	3155660080	0
20	5-i	Cable TV	12633.46	3005660130	allow $3600
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
Total Other Ancillary Costs			$ 46,512	$ -	$ -
			$ -		

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
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)
27	14 c1	General liability Insurance Adjust	(54,830.67)	0	0
27	14c1	General liability Insurance Adjust	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
Total Other Adjustments			$ (54,831)	$ -	$ -
			$ -		

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
Total Unallowable Building Interest			$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-30 Rev.10/2005

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	8,302,489	8,302,489		
b. Medicaid Room and Board Contractual Allowance **	$	(4,262,668)	(4,262,668)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	4,143,317	4,143,317		
b. Medicare Room and Board Contractual Allowance **	$	(1,396,035)	(1,396,035)		
4. a. Private-Pay Residents and Other	$	3,340,650	3,340,650		
b. Private-Pay Room and Board Contractual Allowance **	$	(1,396,350)	(1,396,350)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	240,197	240,197		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(80,931)	(80,931)		
c. Prescription Drugs - Non-Medicare	$	179,831	179,831		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(76,630)	(76,630)		
2. a. Medical Supplies - Medicare	$	6,197	6,197		
b. Medical Supplies - Medicare Contractual Allowance **	$	(2,088)	(2,088)		
c. Medical Supplies - Non-Medicare	$	85	85		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(36)	(36)		
3. a. Physical Therapy - Medicare	$	1,097,196	1,097,196		
b. Physical Therapy - Medicare Contractual Allowance **	$	(369,685)	(369,685)		
c. Physical Therapy - Non-Medicare	$	498,076	498,076		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(208,887)	(208,887)		
4. a. Speech Therapy - Medicare	$	122,136	122,136		
b. Speech Therapy - Medicare Contractual Allowance **	$	(41,152)	(41,152)		
c. Speech Therapy - Non-Medicare	$	39,311	39,311		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(16,914)	(16,914)		
5. a. Occupational Therapy - Medicare	$	1,224,260	1,224,260		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(412,498)	(412,498)		
c. Occupational Therapy - Non-Medicare	$	515,922	515,922		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(216,814)	(216,814)		
6. a. Other *(Specify)* - Medicare	$	37,350	37,350		
b. Other *(Specify)* - Non-Medicare	$	14,832	14,832		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	11,281,161	11,281,161		
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)*	$	501	501		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	1,297	1,297		
V. Total Other Revenue (1 thru 8)	$	1,798	1,798		
VI. Total All Revenue (III +V)	$	11,282,959	11,282,959		

* *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)
II-6-a	Medicare Part A	X-Ray	20,269.80	-	0
II-6-a	Medicare Part A	Radiology Service	-	-	0
II-6-a	Medicare Part A	Outpatient Therapy Program	-	-	0
II-6-a	Medicare Part A	Laboratory	31,546.54	-	0
II-6-a	Medicare Part A	Respiratory Therapy & Supplie	1,318.83	-	0
II-6-a	Medicare Part A	Nursing Treatment Supplies	-	-	0
II-6-a	Medicare Part A	Audiology	27.75	-	0
II-6-a	Medicare Part A	Incontinency	-	-	0
II-6-a	Medicare Part A	Oxygen & Supplies	-	-	0
II-6-a	Medicare Part A	Physician Visit	-	-	0
II-6-a	Medicare Part A	Ambulance	-	-	0
II-6-a	Medicare Part A	Flu Shot	3,166.00	-	0
II-6-a	Contractuals-Medicare	X-Ray	(6,829.64)	-	0
II-6-a	Contractuals-Medicare	Radiology Service	-	-	0
II-6-a	Contractuals-Medicare	Outpatient Therapy Program	-	-	0
II-6-a	Contractuals-Medicare	Laboratory	(10,629.18)	-	0
II-6-a	Contractuals-Medicare	Respiratory Therapy & Supplie	(444.36)	-	0
II-6-a	Contractuals-Medicare	Nursing Treatment Supplies	-	-	0
II-6-a	Contractuals-Medicare	Audiology	(9.35)	-	0
II-6-a	Contractuals-Medicare	Incontinency	-	-	0
II-6-a	Contractuals-Medicare	Oxygen & Supplies	-	-	0
II-6-a	Contractuals-Medicare	Physician Visit	-	-	0
II-6-a	Contractuals-Medicare	Ambulance	-	-	0
II-6-a	Contractuals-Medicare	Flu Shot	(1,066.74)	-	0
Total Other Resident Revenue - Medicare			$ 37,350	$ -	$ -
			$ (0)		

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-b	Medicaid	X-Ray	-	-	-
II-6-b	Medicaid	Radiology Service	-	-	-
II-6-b	Medicaid	Outpatient Therapy Program	-	-	-
II-6-b	Medicaid	Laboratory	10.81	-	-
II-6-b	Medicaid	Respiratory Therapy & Supplie	164.00	-	-
II-6-b	Medicaid	Nursing Treatment Supplies	-	-	-
II-6-b	Medicaid	Audiology	-	-	-
II-6-b	Medicaid	Incontinency	-	-	-
II-6-b	Medicaid	Oxygen & Supplies	-	-	-
II-6-b	Medicaid	Physician Visit	-	-	-
II-6-b	Medicaid	Ambulance	-	-	-
II-6-b	Medicaid	Flu Shot	-	-	-
II-6-b	Contractuals Medicaid	X-Ray	-	-	-
II-6-b	Contractuals Medicaid	Radiology Service	-	-	-
II-6-b	Contractuals Medicaid	Outpatient Therapy Program	-	-	-
II-6-b	Contractuals Medicaid	Laboratory	(5.55)	-	-
II-6-b	Contractuals Medicaid	Respiratory Therapy & Supplie	(84.20)	-	-
II-6-b	Contractuals Medicaid	Nursing Treatment Supplies	-	-	-
II-6-b	Contractuals Medicaid	Audiology	-	-	-
II-6-b	Contractuals Medicaid	Incontinency	-	-	-
II-6-b	Contractuals Medicaid	Oxygen & Supplies	-	-	-
II-6-b	Contractuals Medicaid	Physician Visit	-	-	-

II-6-b	Contractuals Medicaid	Ambulance	-	-	-
II-6-b	Contractuals Medicaid	Flu Shot	-	-	-
II-6-b	Private and Other	X-Ray	9,407.85	-	-
II-6-b	Private and Other	Radiology Service	-	-	-
II-6-b	Private and Other	Outpatient Therapy Program	-	-	-
II-6-b	Private and Other	Laboratory	15,346.36	-	-
II-6-b	Private and Other	Respiratory Therapy & Supplie	584.08	-	-
II-6-b	Private and Other	Nursing Treatment Supplies	-	-	-
II-6-b	Private and Other	Audiology	-	-	-
II-6-b	Private and Other	Incontinency	-	-	-
II-6-b	Private and Other	Oxygen & Supplies	-	-	-
II-6-b	Private and Other	Physician Visit	-	-	-
II-6-b	Private and Other	Ambulance	-	-	-
II-6-b	Private and Other	Flu Shot	-	-	-
II-6-b	Private and Other	Capitation Contracts	-	-	-
II-6-b	Contractuals-Non-Medicaid	X-Ray	(3,932.36)	-	-
II-6-b	Contractuals-Non-Medicaid	Radiology Service	-	-	-
II-6-b	Contractuals-Non-Medicaid	Outpatient Therapy Program	-	-	-
II-6-b	Contractuals-Non-Medicaid	Laboratory	(6,414.59)	-	-
II-6-b	Contractuals-Non-Medicaid	Respiratory Therapy & Supplie	(244.14)	-	-
II-6-b	Contractuals-Non-Medicaid	Nursing Treatment Supplies	-	-	-
II-6-b	Contractuals-Non-Medicaid	Audiology	-	-	-
II-6-b	Contractuals-Non-Medicaid	Incontinency	-	-	-
II-6-b	Contractuals-Non-Medicaid	Oxygen & Supplies	-	-	-
II-6-b	Contractuals-Non-Medicaid	Physician Visit	-	-	-
II-6-b	Contractuals-Non-Medicaid	Ambulance	-	-	-
II-6-b	Contractuals-Non-Medicaid	Flu Shot	-	-	-
			-		
Total Other Resident Revenue			$ 14,832	$ -	$ -
			$ 0		

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Pg 30 line1	430055	Interest On Overdue Accounts	501.11	0	0
0	0	0	-	0	0
0	0	0	-	0	0
Total Interest Income			$ 501	$ -	$ -
			$ 0		

Schedule of Other Revenue

Page Ref	Description		CCNH	RHNS	(Specify)
Pg 30 line 1	0	430060	-	-	-
Pg 30 line 1	MEDICAL RECORDS	0	1,147.17	-	-
Pg 30 line 1	RESIDENT COUNCIL FU	0	150.00	-	-
Pg 30 line 1	0	0	-	-	-
Pg 30 line 1	0	0	-	-	-
Pg 30 line 1	0	0	-	-	-
Total Other Revenue			$ 1,297	$ -	$ -
			$ 0		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-31 Rev. 6/95

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 14,981
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,154,224
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ (3,727)
4 Inventories				$ 30,064
5. Prepaid Expenses				$ 67,452
a. Prepaid Expenses				
b. Prepaid Property Tax		60,900		
c. Prepaid Personal Property Tax				
d. Prepaid Personal Property Tax		6,552		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,262,993
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	58,743		$ 48,625
	Accum. Depreciation	10,118	Net	
3. Buildings	*Historical Cost	182,055		$ 151,434
	Accum. Depreciation	30,621	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	261,665		$ 155,104
	Accum. Depreciation	106,561	Net	
6. Movable Equipment	*Historical Cost	219,424		$ 88,227
	Accum. Depreciation	131,197	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 443,390

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

(*Carry Total forward to next page*)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-32 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	32	37

Account				Amount
			Total Brought Forward:	$ 1,706,383
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 (*itemize*)			$
	6. Loans to Owners or Related Parties (*itemize*)			$
	Name and Address	Amount	Loan Date	
	7. Other Assets (*itemize*)			$ (4,823,438)
	I/C Due to/Due From Owned		(4,823,438)	
	I/C Due to/Due From Multicare			
D-8.	***Total Investments and Other Assets*** (Lines D1 thru 7)			$ (4,823,438)
D-9.	***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$ (3,117,055)

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-33 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 426,449
2. Notes Payable (*itemize*)					$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)					$ 196,364
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 656
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$ 239,862
Accrued Provider/Bed Tax	109,998	Accr Gross Rec Tax-FY1	16,440		
A/R Credit Gross Up Liability	61,668	Deferred Revenue	19,110		
Accr Exp Fuel Oil, Water and Sewer	10,547	Accr Exp Suspense	(289)		
Accr Exp Other	22,327	Accr Sales and Use Tax -	61		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 863,331

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

(Carry Total forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-34 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	34	37

Account	Amount
Total Brought Forward:	863,331
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$	(102,916)
LT Debt-Financing Obligation (102,916)		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$	(102,916)
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$	760,415

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-35 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Cente	2202-C	9/30/2017	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (3,314,787)
	6. Gain or Loss for Period 10/1/2016 thru 9/30/2017	$ (562,684)
	7. Total Net Worth	$ (3,877,471)
C.	***Total Reserves and Net Worth***	$ (3,877,471)
D.	***Total Liabilities, Reserves, and Net Worth***	$ (3,117,056)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-36 Rev. 6/95

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2016			$ (3,314,787)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 11,282,959
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 11,845,643
D.	Net Income or Deficit			$ (562,684)
E.	Balance			$ (3,877,471)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period*** 09/30/17			$ (3,877,471)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-37 Rev. 9/2002

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2017	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed
Thomas Farnan	Sr. Director of Reimbursement	12/14/2017

Printed Name of Preparer

Thomas Farnan Title -Sr. Director of Reimbursement

Addres Address	Phone Number
200 Brickstone Square, Andover, MA 01810	978-247-5029