State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2017

Name of Facility (as licensed) WORCESTER SKILLED CARE CENTER, INC	
Address (No. & Street, City, State, Zip Code) 59 ACTON STREET ,WORCESTER MA. 01604	
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☑ MA Neuro ☑ CT/NY Neuro	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

License Numbers:	CCNH	MA Neuro	CT/NY Neuro	Medicare Provider
	0723MA			225219

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	26450		

For Department Use Only

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

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General Information

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WORCESTER SKILLED CARE CENTER, INC	0723MA	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 WORCESTER SKILLED CARE CENTER, INC [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) SUSAN JENNEY			Printed Name (Owner)	
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 WORCESTER SKILLED CARE CENTER, INC	Period Covered:		From 10/1/2016	To 9/30/2017
Address of Facility 59 ACTON STREET ,WORCESTER MA. 01604				
Report Prepared By CLIFTONLARSONALLLEN LLP	Phone Number 617-984-8100		Date 2/26/2018	

Item		Total	CCNH	MA Neuro	CT/NY Neuro
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.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
508-791-3147	9/30/2017	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
WORCESTER SKILLED CARE CENTER, INC	59 ACTON STREET ,WORCESTER MA. 01604

License Numbers:	CCNH	MA Neuro	CT/NY Neuro	Medicare Provider No.
	0723MA			225219

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☑ Rest Home with Nursing Supervision only (RHNS) ☑ CT/NY Neuro

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.:	
SUSAN JENNEY		NH5353 (Massachusetts)

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER,	0723MA	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
SENIOR RESIDENTIAL CARE WORCESTER, INC	63KENDRICK ST., NEEDHAM, MA 02494	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
SCOTT SCHUSTER	63 KENDRICK ST., NEEDHAM, MA 02494	PRESIDENT	92.5
BRIAN CALLAHAN	63 KENDRICK ST., NEEDHAM, MA 02494		7.5
Names of Stockholders Owning at Least 10% of Shares			
SCOTT SCHUSTER	63 KENDRICK ST., NEEDHAM, MA 02494	PRESIDENT	92.5

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ⊙ No

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
WEST RIVER PHARMACY UBC	140 LOCKE DR., MARLBORO, MA 01752	⊙	○	10%	PHARMACY SERVICES	Page 20,l5j &var	323,837	323,837
WINGATE HEALTHCARE, INC	63 KENDRICK ST., NEEDHAM, MA 02494	○	⊙		MANAGEMENT SERVICES	Page 16, m12	554,432	554,432
WINCATE HEALTHCARE INC	63 KENDRICK ST., NEEDHAM, MA 02494	○	⊙		COMPUTER SERVICES	Page 16, m13	4,500	4,500
WINGATE HEALTHCARE INC	63 KENDRICK ST., NEEDHAM, MA 02494	○	⊙		CENTRAL OFFICE EXPENSE	Page 16, m13	30,463	30,463
		○	⊙					
		○	○					
		○	○					
		○	○					
		○	○					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, IN	0723MA	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.

Because of significant differences in cost of care between neurobehavioral residents and non-neurobehavioral residents costs are allocated between non-neurobehavioral residents ("CCH" heading in 1st column throughout this cost report) and neurobehavioral residents, which are further allocated between Massachusetts neurobehavioral residents ("MA Neuro" heading in 2nd column throughout this cost report) and Connecticut & New York neurobehavioral residents ("CT/NY Neuro" heading in 3rd column throughout this cost report). Nursing costs are allocated by applying facility staffing FTEs (3.2 for CCH, 3.6 for Neuro) to resident days for each column; ancillary costs are allocated based on estimated percentage of residents receiving the services (rehab services: 25% CCH, 75% CT/NY Neuro; non-rehab anicllaries: 5% CCH, 95% CT/NY Neuro); specific neurobehavioral salaries & other costs are allocated between MA Neuro & CT/NY Neuro based on resident days for those categories. All other costs are allocated among the three columns based on resident days. The behavioral residents were broken out into two columns since CT/NY are all inclusive rates which include all ancillary services. MA is not all inclusive and all ancillary services are billed directly by a third party.

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

Pharmacy services, computer service and therapy service expense is based on usage. Management services are 5% of revenue. Central office expense is allocated based on number of beds.

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.

N/A

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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
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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
CSI LEASING, INC 9900 OLD OLIVE ST. RD, STE 101, ST LOUIS, MO 63141	○	⊙	EQUIPMENT	FY14	>1 YEAR		7,399
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
						Total ***	7,399

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

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

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General Information and Questionnaire
Accounting Basis

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 CLIFTONLARSONALLEN LLP	300 CROWN COLONY DR., STE 310, QUINCY, MA 02169
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	AUDIT, TAX & COST REPORTING SERVICES	$ 22,635
2		$
3		$
4		$
		Charge for Services Provided: $ 22,635

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

⊙ Yes ○ No — Page 15, Line 1.d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 See Attached	
2	
3	
4	
5	

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	See Attached	$ 39,814
2		$
3		$
4		$
5		$
		Charge for Services Provided: $ 39,814

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

⊙ Yes ○ No — Page 15, Line 1.e

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Schedule of Resident Statistics

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					Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
	Total All Levels	Total CCNH Level	Total MA Neuro Level	Total CT/NY Neuro	Total	CCNH	Total MA Neuro Level	CT/NY Neuro	Total	CCNH	Total MA Neuro Level	CT/NY Neuro
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	173	173			173	173			173	173		
B. On last day of THIS report period	173	173			173	173			173	173		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	165	112	5	48	165	112	5	48	156	105	5	46
B. As of midnight of THIS report period	143	103	4	36	145	105	4	36	143	103	4	36
3. Total Number of Days Care Provided During Period												
A. Medicare	916	916			712	712			204	204		
B. Medicaid (Conn.)	2,460			2,460	1,908			1,908	552			552
C. Medicaid (other states)	47,101	38,114	1,460	7,527	35,500	28,813	1,092	5,595	11,601	9,301	368	1,932
D. Private Pay												
E. State SSI for RCH												
F. Other (Specify)	2,820	2,820			2,044	2,044			776	776		
G. Total Care Days During Period (3A thru F)	53,297	41,850	1,460	9,987	40,164	31,569	1,092	7,503	13,133	10,281	368	2,484
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	589	578		11	437	426		11	152	152		
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	53,886	42,428	1,460	9,998	40,601	31,995	1,092	7,514	13,285	10,433	368	2,484

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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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	MA Neur	CT/NY Neuro	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	CT/NY Neuro	

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	CT/NY Neuro
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	CT/NY Neuro	R.C.H.	ICF-MR
No. of Residents	2	136		5				
Per Diem Rate								
a. One bed rm.				360.00				
b. Two bed rms.				336.00				
c. Three or more bed rms.				324.00				

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	MA Neuro	CT/NY Neuro
A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. ***Total Physical Therapy Treatments***				
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. ***Total Speech Therapy Treatments***				
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. ***Total Occupational Therapy Treatments***				

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	MA Neuro	Hours	CT/NY Neuro	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)	103,976	1,550	3,578	53	24,501	365
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	252,389	9,101	8,685	313	59,475	2,145
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers						
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	42,211	1,638	1,453	56	9,947	386
b. Other Maintenance Workers	31,896	1,624	1,098	56	7,516	383
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	48,817	2,170	1,680	75	11,503	511
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	171,034	3,219	5,885	111	40,304	758
b. RN						
1. Direct Care	749,242	18,843	107,404	2,701	735,494	18,498
2. Administrative**	172,160	4,555	5,924	157	40,569	1,073
c. LPN						
1. Direct Care	667,048	22,691	95,621	3,253	654,808	22,274
2. Administrative**						
d. Aides and Attendants	1,107,254	70,022	158,724	10,038	1,086,936	68,737
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	72,744	5,645	2,503	194	17,142	1,330
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	39,957	1,257	1,375	43	9,416	
n. Marketing	61,348		2,111		14,456	
o. Other (Specify)						
See Attached Schedule			166,202	8,596	1,138,142	58,865
A-13. Total Salary Expenditures	3,520,077	142,315	562,243	25,646	3,850,210	175,326

* 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		MA Neuro		CT/NY Neuro	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Salaries- Director of Neurobehavioral			$ 8,477	259	$ 58,049	$ 1,771
Salaires-Behavioral Spec			$ 93,188	6,425	$ 638,146	44,000
Salaries-Respiratory Therapy			$ 51,408	1,505	$ 352,042	10,307
Social Service - Neurobehavioral			$ 13,129	407	$ 89,905	2,787
Total	$ -	-	$ 166,202	8,596	$ 1,138,142	58,865

Schedule of Other Fees (Page 13)

	CCNH		MA Neuro		CT/NY Neuro	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Psyciatric Consultant					$ 6,287	84
Occupational Therapy					$ 132,356	1,557
Total	$ -	-	$ -	-	$ 138,643	1,641

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

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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	CT/NY Neuro							
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.

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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
WORCESTER SKILLED CARE CENTER, INC	0723MA	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	MA Neuro	CT/NY Neuro							
Section III - Administrators* **										
SUSAN JENNEY	103,976	3,578	24,501		Administrator	1,968	A. 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.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total Cost and Hours					
Item	CCNH	Hours	MA Neuro	Hours	CT/NY Neuro	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	19,615	217	675	7	4,622	51
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	19,847	441			59,542	1,322
b. Other						
6. Social Worker	6,614	121	228	4	1,559	29
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	95,744	647	3,295	22	22,562	153
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	20,264	261			60,791	784
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	85,828	1,499	12,303	215	84,253	1,471
2. Administrative***						
b. LPN						
1. Direct Care	45,168	829	6,475	119	44,339	813
2. Administrative***						
c. Aides	11,992	545	413	19	2,826	128
d. Other						
12. Other (Specify) See Attached Schedule					138,643	1,641
B-13 Total Fees Paid in Lieu of Salaries	305,071	4,559	23,388	386	419,137	6,392

* 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.

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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
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2017	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
		○	⊙	
West River Pharmacy	Pharmacy Consulting	⊙	○	Common Ownership
		○	⊙	
		○	⊙	
Rehab Care Group, Inc.	PT Therapist	○	⊙	
William H. Johnson	Social Worker	○	⊙	
Bond Medical Consultants	Medical Director Physician	○	⊙	
Daniel Tanenbaum, MD	Physician	○	⊙	
Rehab Care Group, Inc.	Speech Therapist	○	⊙	
Rehab Care Group, Inc.	Occupational Therapist	○	⊙	
Expert Staffing	Nursing	○	○	
Worldwide Staffing	Nursing	○	○	
MAS Medical Staffing	Nursing	○	⊙	
Expert Staffing	Nursing	○	⊙	
West Central Family	Pschiatric Services	○	⊙	
Anthony B Joseph MD	Pschiatric Consultant	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
/	/	○	⊙	
/	/	○	⊙	
/	/	○	⊙	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, IN(	0723MA	9/30/2017	15	37

Item		Total	CCNH	MA Neuro	CT/NY Neuro
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	128,847	57,176	9,132	62,538
2. Disability Insurance	$				
3. Unemployment Insurance	$				
4. Social Security (F.I.C.A.)	$	649,045	288,015	46,003	315,027
5. Health Insurance	$	463,021	205,467	32,818	224,736
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	21,043	9,338	1,491	10,214
7. Pensions (Non-Discriminatory)	$	8,869	3,936	629	4,305
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	9,498	4,215	673	4,610
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	140,362	110,516	3,803	26,043
d. Accounting and Auditing	$	22,635	17,822	613	4,200
e. Legal (*Services should be fully described on Page 7)*	$	39,814	31,348	1,079	7,387
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	65,169	51,312	1,766	12,091
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	35,127	27,658	952	6,517
2. Cellular Phones	$	752	592	20	140
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*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	1,145,114	901,624	31,026	212,464
Subtotal	$	2,729,296	1,709,018	130,006	890,272

* 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	MA NEURO	CT/NY Neuro
Employee Benefits Other	$ 4,215	$ 673	$ 4,610
Total	$ 4,215	$ 673	$ 4,610

Schedule of Other Taxes

Description	CCNH	MA NEURO	CT/NY Neuro
Total	$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2017	16	37

Item		Total	CCNH	MA Neuro	CT/NY Neuro
Subtotals Brought Forward:		2,729,296	1,709,018	130,006	890,272
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	3,225	2,539	87	598
3. Gifts to Staff and Residents	$	1,435	1,130	39	266
4. Employee Travel	$	4,320	3,401	117	802
5. Education Expenses Related to Seminars and Conventions	$	7,093	5,585	192	1,316
6. Automobile Expense (*not purchase or depreciation*)	$	2,511	1,977	68	466
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	8,369	6,589	227	1,553
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	11,681	9,197	316	2,167
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	7,986	6,288	216	1,482
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	20,057	15,792	543	3,721
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions***	$	484	381	13	90
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$	554,432	436,541	15,022	102,869
13. Other (*Specify*)	$	233,370	183,748	6,323	43,299
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	3,584,259	2,382,187	153,170	1,048,902

* 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	MA Neuro	CT/NY Neuro
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH	MA Neuro	CT/NY Neuro
Marketing	$ 9,197	$ 316	$ 2,167
Total Other Advertising	$ 9,197	$ 316	$ 2,167

Schedule of Dues

Description	CCNH	MA Neuro	CT/NY Neuro
JCAHO	$ 3,149	$ 108	$ 742
License & Dues -Patient Relatied	$ 11,285	$ 388	$ 2,659
License & Dues- Non Patient related	$ 1,358	$ 47	$ 320
Total Dues	$ 15,792	$ 543	$ 3,721

Schedule of Contributions

Description	CCNH	MA Neuro	CT/NY Neuro
Donations	$ 381	$ 13	$ 90
Total Contributions	$ 381	$ 13	$ 90

Schedule of Other Administrative and General

Description	CCNH	MA Neuro	CT/NY Neuro
Physician Care	$ 33,850	$ 1,165	$ 7,977
Payroll Processing Fees	$ 17,658	$ 608	$ 4,161
Computer Expense	$ 46,955	$ 1,616	$ 11,065
Bookkeeping Service	$ 8,219	$ 283	$ 1,937
Professional Service	$ 32,684	$ 1,125	$ 7,702
Central Office Expense	$ 23,986	$ 825	$ 5,652
Bank Fees	$ 14,285	$ 492	$ 3,366
Late Charges & Fines & Penalties	$ 5,955	$ 205	$ 1,403
Miscellaneous Expenses	$ 157	$ 5	$ 37
Total Other Administrative and General	$ 183,748	$ 6,323	$ 43,299

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
WORCESTER SKILLED CARE CENTE	0723MA	9/30/2017	17 | 37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
WINGATE HEALTHCARE, INC, 63 KENDRICK ST., NEEDHAM, MA 02494	554,432	HOME OFFICE SERVICES INCLUDING ACCOUNTING, FINANCE, NURSING, ADMINISTRATION, OPERATIONS MANAGEMENT, HUMAN RESOURCES	pg. 16, m12
WINGATE HEALTHCARE, INC, 63 KENDRICK ST., NEEDHAM, MA 02494	34,963	Central Office and Computer Services	pg 16, m13
WEST RIVER PHARMACY, 63 KENDRICK ST., NEEDHAM, MA 02494	323,837	Pharmacy Services	pg 20 l5j, pg 13 lb3 & various

*** 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.**

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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
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2017	18 | 37

Item		Total	CCNH	MA Neuro	CT/NY Neuro
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	119	94	3	22
2. Non-Food Supplies	$	1,259	991	34	234
3. Other (*Specify*)_____ Dietary Supplements	$	38,636	30,421	1,047	7,169
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	822,328	647,473	22,280	152,575
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	862,342	678,979	23,364	159,999

2F. Dietary Questionnaire		Total	CCNH	RHNS	CT/NY Neuro
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.

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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
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2017	19 | 37

Item		Total	CCNH	MA Neuro	CT/NY Neuro
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	214,792	42,280	21,982	150,530
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	214,792	42,280	21,982	150,530

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.

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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
WORCESTER SKILLED CARE CENTER, II	0723MA	9/30/2017	20	37

Item			Total	CCNH	MA Neuro	CT/NY Neuro
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	27,120	21,353	735	5,032
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	214,792	169,120	5,820	39,852
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	241,912	190,473	6,554	44,884
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$				
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	471,474	371,223	12,774	87,477
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$				
f. X-rays and Related Radiological Procedures***		$				
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$				
i. Recreation		$	15,270	12,023	414	2,833
j. Other (Specify)**** See Attached Schedule		$	476,797	78,063		398,734
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	963,541	461,309	13,188	489,044

* 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	MA Neuro	CT/NY Neuro
Ambulance	$ 610		$ 11,595
X-ray	$ 141		$ 2,670
Pharmacy	$ 67,780		$ 203,339
Complex Medical	$ 5,610		$ 106,591
Oxygen	$ 1,296		$ 24,627
Laboratory	$ 1,797		$ 34,149
IV	$ 830		$ 15,763
Total Other Resident Care	$ 78,063	$ -	$ 398,734

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

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, INC	0723MA	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	MA Neuro	CT/NY Neuro	Pg	Line
HEALTHCARE SERVICES GROUP. INC	STE 300 BENSALEM, PA 19020	○	⊙		HOUSEKEEPING SERVICES	169,120	5,820	39,852	20	4b
HEALTHCARE SERVICES GROUP. INC	STE 300 BENSALEM, PA 19020	○	⊙		LAUNDRY SERVICES	42,280	21,982	150,530	19	3b
BULK TV & INTERNET	#100, RALEIGH, NC 27615	○	⊙		CABLE SERVICES	14,440	497	3,403	22	6a
AJ LETOURNEAU, INC	CUTOFF, WORCESTER, MA	○	⊙		WASTE MANAGEMENT	18,728	644	4,413	22	6a
HEALTHCARE SERVICES GROUP. INC	STE 300 BENSALEM, PA 19020	○	⊙		DIETARY SERVICES	647,473	22,280	152,575	18	2b
SAFEGUARD RECORDS MANAGEMENT	WORCESTER, MA 01610	○	⊙		RECORD MANAGEMENT	7,887	271	1,859	22	6a
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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).

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

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, I	0723MA	9/30/2017	22	37

Item		Total	CCNH	MA Neuro	CT/NY Neuro
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	241,114	94,922	18,628	127,564
b. Heat	$	42,888	33,769	1,162	7,957
c. Light & Power	$	168,345	132,549	4,561	31,235
d. Water	$	89,472	70,447	2,424	16,601
e. Equipment Lease (*Provide detail on page 6*)	$	7,399	5,826	200	1,373
f. Other (*itemize*)	$	31,928	25,139	865	5,924
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	581,146	362,652	27,841	190,653
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	75,869	59,737	2,056	14,077
c. Non-Movable Equipment	$				
d. Movable Equipment	$	59,633	46,953	1,616	11,064
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	135,502	106,690	3,671	25,141
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	$	1,447,561	1,139,760	39,221	268,580
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	197,064	155,161	5,339	36,563
c. Personal property taxes	$	25,035	19,712	678	4,645
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,805,162	1,421,323	48,909	334,929

* 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	MA Neuro	CT/NY Neuro
Rent Other	$ 11,810	$ 406	$ 2,783
Equipment Rental	$ 13,329	$ 459	$ 3,141
Total Other Repairs and Maintenance	$ 25,139	$ 865	$ 5,924

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, INC	0723MA	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								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period	693,525		693,525	312,072	SL	Var	69,353	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	136,943		136,943				6,516	
B-4. Subtotal								75,869
C. **Non-Movable Equipment**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquisition								
	Yes	No	Month	Year	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
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. VAN	x		7	2007	51,226		51,226	51,226	SL			
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					804,244		804,244	552,037			56,471	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					62,445		62,445				3,162	
D-3. Subtotal												59,633
E. ***Total Depreciation***												135,502

WORCESTER SKILLED CARE CENTER, INC
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Schedule of Land Improvements Acquired during this report period

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

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

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
SEE ATTACHED	SEE ATTACHED	$ 136,943		$ 6,516	
Total additions for Building Improvements		$ 136,943		$ 6,516	*
Deletions:					
Total deletions for Building Improvements		$ -		$ -	**

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

Schedule of Non-Movable Equipment Acquired during this report period

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
SEE ATTACHED	SEE ATTACHED	$ 62,445		$ 3,162	
Total additions for Movable Equipment		$ 62,445		$ 3,162	*
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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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, INC	0723MA	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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CEN	0723MA	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	173
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
Care Capital Prop. 353 N. Clark Ste 2000. Chicago, IL 60654	Land & Building	01/31/06	1/31/06-2/1/20	1,447,561

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.

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

Name of Facility	License No.	Report for Year Ended	Page of
WORCESTER SKILLED CARE CE	0723MA	9/30/2017	26 | 37

Item		Total	CCNH	MA Neuro	CT/NY Neuro
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*)

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

Name of Facility	License No.	Report for Year Ended	Page of
WORCESTER SKILLED CARE C	0723MA	9/30/2017	27 | 37

Item	Total	CCNH	MA Neuro	CT/NY Neuro
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 on working capital				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $				
14. Insurance				
a. Insurance on Property (buildings only) $	12,000	9,448	325	2,226
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	135,150	106,413	3,662	25,076
2. Fire and Extended Coverage $				
3. Other (*Specify*) $				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	147,150	115,861	3,987	27,302
15. ***Total All Expenditures (A-13 thru C-14)*** $	17,080,430	9,480,212	884,628	6,715,590

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2017	28 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	MA Neuro	CT/NY Neuro
Page 10 - Salaries and Wages								
1.			Outpatient Service Costs	$				
2.	10	12.n.	Salaries not related to Resident Care	$	77,915	61,348	2,111	14,456
3.	10	12.g.	Occupational Therapy	$				
4.			Other - See attached Schedule	$				
Page 13 - Professional Fees								
5.			Resident Care Physicians **	$				
6.			Occupational Therapy	$				
7.			Other - See attached Schedule	$				
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.	15	1.c	Bad Debts	$	140,362	110,516	3,803	26,043
10.	15	1.e	Accounting & Legal	$	12,869	10,133	349	2,387
11.			Telephone	$				
12.	15	1.h.2	Cellular Telephone	$	752	592	20	140
13.			Life insurance premiums on the life of Owners, Partners, Operators	$				
14.	16	3	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	m3	Unallowable Advertising *	$	11,681	9,197	316	2,167
19.			Income Tax / Corporate Business Tax	$				
20.			Fund Raising / Contributions	$	484	381	13	90
21.			Unallowable Management Fees	$				
22.	30	IV7	Barber and Beauty	$				
23.			Other - See attached Schedule	$	21,883	12,971	1,136	7,777
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)	$	265,946	205,138	7,749	53,059

* 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	MA Neuro	CT/NY Neuro
Total Other Salaries Adjustment			$ -	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	MA Neuro	CT/NY Neuro
Total Other Fees Adjustments			$ -	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	MA Neuro	CT/NY Neuro
15	1a	MARKETING BENEFITS	$ 5,500	$ 879	$ 6,016
16	M13	Late Charges & Fines & Penalties	$ 5,955	$ 205	$ 1,403
16	M13	Miscellaneous Expenses	$ 157	$ 5	$ 37
16	M8	License & Dues- Non Patient related	$ 1,358	$ 47	$ 320
Total Other A&G Adjustments			$ 12,971	$ 1,136	$ 7,777

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

Name of Facility	License No.	Report for Year Ended	Page of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2017	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	MA Neuro	CT/NY Neuro
			Subtotals Brought Forward $	265,946	205,138	7,749	53,059
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs $				
28.	20	5d	Ambulance/Limousine $				
29.	20	5f	X-rays, etc $				
30.	20	5h	Laboratory $				
31.			Medical Supplies $				
32.	20	5e2	Oxygen (non emergency) $				
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	476,797	78,063		398,734
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 $	2,980	2,346	81	553
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)*** $	745,723	285,548	7,830	452,346

*** 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.

Attachment Page 29

WORCESTER SKILLED CARE CENTER, INC
9/30/2017

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	MA Neuro	CT/NY Neuro
		Ambulance	$ 610	$ -	$ 11,595
		X-ray	$ 141	$ -	$ 2,670
		Pharmacy	$ 67,780	$ -	$ 203,339
		Complex Medical	$ 5,610	$ -	$ 106,591
		Oxygen	$ 1,296	$ -	$ 24,627
		Laboratory	$ 1,797	$ -	$ 34,149
		IV	$ 830	$ -	$ 15,763
Total Other Ancillary Costs			$ 78,063	$ -	$ 398,734

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	MA Neuro	CT/NY Neuro
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	MA Neuro	CT/NY Neuro
Total Other Property Adjustments			$ -	$ -	$ -

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	MA Neuro	CT/NY Neuro
30	IV, 8	Other Income	$ 2,346	$ 81	$ 553
Total Other Adjustments			$ 2,346	$ 81	$ 553

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	MA Neuro	CT/NY Neuro
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTE	0723MA	9/30/2017	30	37

Item		Total	CCNH	MA Neuro	CT/NY Neuro
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	953,727			953,727
b. Medicaid Room and Board Contractual Allowance **	$				
2. a. Medicaid (*All other states*)	$	13,063,926	10,286,090	353,957	2,423,879
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	490,997	490,997		
b. Medicare Room and Board Contractual Allowance **	$				
4. a. Private-Pay Residents and Other	$	1,299,853	1,299,853		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	40,524	40,524		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(40,524)	(40,524)		
c. Prescription Drugs - Non-Medicare	$	68,267	17,067		51,200
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(68,267)	(17,067)		(51,200)
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	138,267	138,267		
b. Physical Therapy - Medicare Contractual Allowance **	$	(84,083)	(84,083)		
c. Physical Therapy - Non-Medicare	$	44,415	11,104		33,311
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(34,116)	(8,529)		(25,587)
4. a. Speech Therapy - Medicare	$	162,445	162,445		
b. Speech Therapy - Medicare Contractual Allowance **	$	(93,384)	(93,384)		
c. Speech Therapy - Non-Medicare	$	51,814	12,954		38,861
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(42,785)	(10,696)		(32,089)
5. a. Occupational Therapy - Medicare	$	259,040	259,040		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(159,763)	(159,763)		
c. Occupational Therapy - Non-Medicare	$	82,761	20,690		62,071
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(79,020)	(19,755)		(59,265)
6. a. Other *(Specify)* - Medicare	$	503	503		
b. Other *(Specify)* - Non-Medicare	$	128	6		122
III. *Total Resident Revenue* (Section I. thru Section II.)	$	16,054,725	12,305,739	353,957	3,395,029
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)*	$	291	229	8	54
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	6,299	4,960	171	1,169
V. Total Other Revenue (1 thru 8)	$	6,590	5,189	179	1,223
VI. Total All Revenue (III +V)	$	16,061,315	12,310,928	354,136	3,396,252

* *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	MA Neuro	CT/NY Neuro
30II6A-CC	X-rRay	$ 1,709		
30II6A-CC	Oxygen	$ 2,614		
30II6A-CC	Laboratory	$ 8,118		
30II6A-CC	IV	$ 1,949		
30II6A-CC	Cont Allowance	$ (13,887)		
Total Other Resident Revenue - Medicare		$ 503	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	MA Neuro	CT/NY Neuro
30II6b-CCI	X-Ray, Oxygen, Lab, IV	$ 1,265		$ 24,028
30II6b-CCI	Cont. Allowance	$ (1,258)		$ (23,907)
30II6b-CCI				
Total Other Resident Revenue		$ 6	$ -	$ 122

Interest Income

Account

Page Ref	Account	Balance	CCNH	MA Neuro	CT/NY Neuro
30IV5-CCI	Interest Income		$ 229	$ 8	$ 54
Total Interest Income			$ 229	$ 8	$ 54

Schedule of Other Revenue

Page Ref	Description	CCNH	MA Neuro	CT/NY Neuro
30IV8-CCI	Special Billing	$ 2,301	$ 79	$ 542
	Bad Debt Recovery	$ 313	$ 11	$ 74
	Other Income	$ 2,346	$ 81	$ 553
Total Other Revenue		$ 4,960	$ 171	$ 1,169

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENT	0723MA	9/30/2017	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 116,281
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,044,719
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 4,462
4 Inventories				$ 17,104
5. Prepaid Expenses				$ 51,890
a. Prepaid Interest				
b. Prepaid Workers Comp Ins		(60,480)		
c. Prepaid Taxes		846		
d. Other Prepaid Expenses		111,524		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 45,508
Net Payroll		8,823		
Employee Loan		742		
Patient Exchange/Exchange other		17,378		
Refund-Contra		18,565		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,279,964
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost	830,468		$ 442,527
	Accum. Depreciation	387,941	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	866,689		$ 255,019
	Accum. Depreciation	611,670	Net	
7. Motor Vehicles	*Historical Cost	51,226		$
	Accum. Depreciation	51,226	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 697,546

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENT	0723MA	9/30/2017	32	37

Account				Amount
			Total Brought Forward:	$ 1,977,510
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				$ 1,561
2. Escrow Deposits				$ (25,086)
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*)				$ (1,679,562)
Name and Address	Amount	Loan Date		
	(1,679,562)			
7. Other Assets (*itemize*)				$ 2,400
Construction in Progress		2,400		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ (1,700,687)
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 276,823

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, I	0723MA	9/30/2017	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 1,162,304
	2. Notes Payable (*itemize*)				$ 345,306
	N/P - Other	345,306			
	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*)				$ 48,908
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 2,225
	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*)				$ 927,516
	Reserve for Medicare Rate Adj	(1,214)	Accrued Prof Svcs	21,695	
	A/P Patient Trust/PNA	110,781	Deferred Rent	496,501	
	Uncashed Checks	1,024	Withheld Life Insurance	(1,145)	
	Accrued Expenses	284,884	401K Due	14,990	
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 2,486,259

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER	0723MA	9/30/2017	34	37

Account	Amount
Total Brought Forward:	2,486,259
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*)	$
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 2,486,259

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

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CEN	0723MA	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	$ 2,812,488
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (4,002,809)
	6. Gain or Loss for Period 10/1/2016 thru 9/30/2017	$ (1,019,115)
	7. Total Net Worth	$ (2,209,436)
C.	***Total Reserves and Net Worth***	$ (2,209,436)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 276,823

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENT	0723MA	9/30/2017	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2016			$ (608,775)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 16,061,315
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 17,080,430
D.	Net Income or Deficit			$ (1,019,115)
E.	Balance			$ (1,627,890)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
	Prior Period Adjustment		(606,341)	
	Adjust depr book to CR basis		24,795	
F-3.	Total Additions			$ (581,546)
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		$ (2,209,436)

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
WORCESTER SKILLED CARE	0723MA	9/30/2017	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☑ MA Neuro	☑ CT/NY Neuro

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
CliftonLarsonAllen LLP	Principal	2/12/2017

Printed Name of Preparer

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