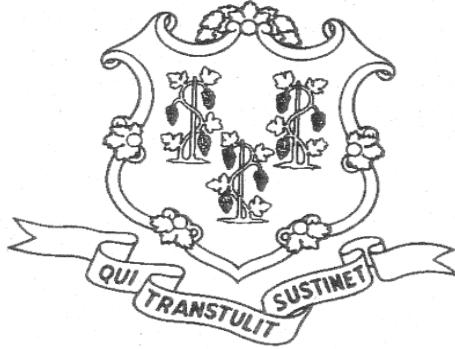


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2020

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	
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020

License Numbers:	CCNH 2202-C	RHNS	(Specify)	Medicare Provider 07-5331
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Medicaid Provider Numbers:	CCNH 000020553	RHNS	ICF-IID
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For Department Use Only

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

General Information

Name of Facility (as licensed) Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2020	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Willows Care and Rehabilitation Center [facility name], for the cost report period beginning October 1, 2019 and ending September 30, 2020, 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) Peter Mongillo		Printed Name (Owner) Lashuan Bethea-VP-Legislative Affairs-Genesis Healthcare		
Subscribed and Sworn to before me:	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 Willows Care and Rehabilitation Center	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 225 Amity Road, Woodbridge, CT 06525				
Report Prepared By Thomas Farnan	Phone Number 978-247-5029	Date 12/28/2020		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$	3,629,335	3,629,335	
5. All other wages paid	\$	719,531	719,531	
6. Total Wages Paid	\$	4,348,866	4,348,866	
7. Total salaries paid	\$	235,857	235,857	
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$	4,584,723	4,584,723	

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-387-0076	Report for Year Ended 9/30/2020	Page 2	of 37
Name of Facility (as shown on license) Willows Care and Rehabilitation Center		Address (No. & Street, City, State, Zip) 225 Amity Road, Woodbridge, CT 06525	
License Numbers: Type of Facility (Check appropriate box(es))	CCNH 2202-C	RHNS (Specify)	Medicare Provider No. 07-5331
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)			
Type of Ownership (Check appropriate box)			
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust			
If this facility opened or closed during report year provide:		Date Opened	Date Closed
Has there been any change in ownership or operation during this report year?		<input type="radio"/> Yes	<input checked="" type="radio"/> No
		If "Yes," explain fully.	
Administrator			
Name of Administrator Peter Mongillo		Nursing Home Administrator's License No.: 1860	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.			
Name		License No.:	

General Information and Questionnaire Partners/Members

General Information and Questionnaire
Corporate Owners

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2020	Page of 3A 37
If this facility is owned or operated as a corporation, provide the following information:			
Legal Name of Corporation Willows Care and Rehabilitation Center	Business Address 101 East State Street, Kennett Square, PA 19348	State(s) in Which Incorporated PA	
Name of Directors, Officers See Attached	Business Address	Title	No. Shares Held by Each
Names of Stockholders Owning at Least 10% of Shares See Attached			

General Information and Questionnaire

Individual Proprietorship

General Information and Questionnaire

Related Parties*

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2020			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?			<input type="radio"/> Yes <input checked="" type="radio"/> No		If "Yes," provide the Name/Address and complete the information on Page 11 of the report.			
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?			<input checked="" type="radio"/> Yes <input type="radio"/> No		If "Yes," provide the following information:			
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Genesis Administrative Services LLC	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Home Office	Pg 16/m12	396,264	396,264
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	64%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	991,685	991,685
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	<input type="radio"/>	<input checked="" type="radio"/>	37%	Staffing Pool	Pg 10/A12, p15-1		
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	85%	Medical Director /NP	Pg 13/B8, Pg 10/A12	15,240	15,240
Career Staffing	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	66%	Outside Agency	Pg 13/B11 pg 10-12, 15	933	933
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	<input checked="" type="radio"/>	<input type="radio"/>	50%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E2	3,432	3,432
Genesis Healthcare Ins Program	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Insurance	Pg 27/14	171,160	171,160
		<input checked="" type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

* Use additional sheets if necessary.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2020	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

1. In the preparation of this Report, were all costs allocated as required?	<input checked="" type="radio"/> Yes <input type="radio"/> No	If "No," explain fully why such allocation was not made.
2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.		
3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)		
<input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.		

General Information and Questionnaire Leases (Excluding Real Property)

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

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes

⊕ No

Total ***

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

** Attach copies of newly acquired leases.

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

General Information and Questionnaire

Accounting Basis

Name of Facility Willows Care and Rehabilitation C	License No. 2202-C	Report for Year Ended 9/30/2020	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

⊕ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

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

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 Included in Management Fee pg. 16 m-12

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Goldman Gruder & Woods LLC	203-899-8900
2 Wiggin And Dana LLP	203-498-4400
3	
4	
5	

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

1 200 Connecticut Ave Norwalk, CT 06854
2 One Century Tower, New Haven, CT 06508
3
4
5

Services Provided by This Firm (*describe fully*)

1	Property Ownership search	\$
2	Deseased record services	\$
3		\$
4		\$
5		\$
		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

Schedule of Resident Statistics

Name of Facility Willows Care and Rehabilitation Center			License No. 2202-C			Report for Year Ended 9/30/2020				Page 8 of 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					90	90						
A. On last day of PREVIOUS report period	90	90										
B. On last day of THIS report period	90	90							90	90		
2. Number of Residents					85	85						
A. As of midnight of PREVIOUS report period	85	85										
B. As of midnight of THIS report period	72	72							72	72		
3. Total Number of Days Care Provided During Period					3,897	3,897			841	841		
A. Medicare	4,738	4,738										
B. Medicaid (Conn.)	16,070	16,070			12,229	12,229			3,841	3,841		
C. Medicaid (other states)												
D. Private Pay	856	856			762	762			94	94		
E. State SSI for RCH												
F. Other (Specify)	4,255	4,255			2,999	2,999			1,256	1,256		
G. Total Care Days During Period (3A thru F)	25,919	25,919			19,887	19,887			6,032	6,032		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds					15	15						
A. Medicaid Bed Reserve Days	15	15										
B. Other Bed Reserve Days	7	7			7	7						
5. Total Resident Days (3G + 4A + 4B)	25,941	25,941			19,909	19,909			6,032	6,032		

Schedule of Resident Statistics (Cont'd)

Name of Facility Willows Care and Rehabilitation Center			License No. 2202-C			Report for Year Ended 9/30/2020			Page 9	of 37	
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:											
Date of Change	Place of Change			Change in Beds				Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost		Gained		CCNH	RHNS	(Specify)	
(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)			
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.											
Change in Resident Days								CCNH	RHNS	(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	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR		
No. of Residents	13	44		15							
Per Diem Rate											
a. One bed rm.											
b. Two bed rms.	620.03	261.26		517.88							
c. Three or more bed rms.											
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)
								2,725	2,725		
A. Medicare - Part B											
B. Medicaid (Exclusive of Part B)											
1. Maintenance Treatments											
2. Restorative Treatments								1,014	1,014		
C. Other								18,885	18,885		
D. Total Physical Therapy Treatments								22,624	22,624		
8. Total Number of Speech Therapy Treatments								115	115		
A. Medicare - Part B											
B. Medicaid (Exclusive of Part B)											
1. Maintenance Treatments											
2. Restorative Treatments								62	62		
C. Other											
D. Total Speech Therapy Treatments								177	177		
9. Total Number of Occupational Therapy Treatments								3,124	3,124		
A. Medicare - Part B											
B. Medicaid (Exclusive of Part B)											
1. Maintenance Treatments											
2. Restorative Treatments								905	905		
C. Other								20,040	20,040		
D. Total Occupational Therapy Treatments								24,069	24,069		

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of		
		2202-C	9/30/2020		37		
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes <input type="radio"/> No					
		Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)		
A. Salaries and Wages*							
1. Operators/Owners (Complete also Sec. I of Schedule A1)							
2. Administrator(s) (Complete also Sec. III of Schedule A1)	135,541	2,120					
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)							
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	263,482	11,179					
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	82,193	2,209					
b. Other Maintenance Workers	27,320	1,429					
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	100,316	1,670					
b. RN							
1. Direct Care	878,254	18,836					
2. Administrative**	94,218	2,071					
c. LPN							
1. Direct Care	1,127,885	31,808					
2. Administrative**							
d. Aides and Attendants	1,439,094	63,256					
e. Physical Therapists							
f. Speech Therapists							
g. Occupational Therapists							
h. Recreation Workers	149,474	5,517					
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	197,062	6,356					
n. Marketing							
o. Other (Specify)							
See Attached Schedule	89,884	3,431					
A-13. Total Salary Expenditures	4,584,723	149,883					

* 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)

Schedule of Other Fees (Page 13)

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 Willows Care and Rehabilitation Center				License No. 2202-C		Report for Year Ended 9/30/2020			Page 11	of 37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section 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		9/30/2020			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	135,541				Management of Center	2,120	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.

B. Report of Expenditures - Professional Fees

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2020		Page 13	of 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	8,145	56			
3. Pharmacist	9,738	199			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	803,840	11,012			
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	72,220	382			
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	11,656	149			
b. Other					
10. Occupational Therapist					
a. Resident Care	144,964	1,986			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	1,571	26			
2. Administrative***					
b. LPN					
1. Direct Care					
2. Administrative***					
c. Aides					
d. Other					
12. Other (Specify) See Attached Schedule	5,130				
B-13 Total Fees Paid in Lieu of Salaries	1,057,263	13,810			

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

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

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

Report of Expenditures

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

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2020		Page 15	of 37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 219,900	219,900			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 42,157	42,157			
4. Social Security (F.I.C.A.)	\$ 339,562	339,562			
5. Health Insurance	\$ 171,492	171,492			
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) See Attached Schedule	\$ 279,315	279,315			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 105,088	105,088			
d. Accounting and Auditing	\$				
e. Legal (<i>Services should be fully described on Page 7</i>)	\$				
f. Insurance on Lives of Owners and Operators (Specify)*	\$				
g. Office Supplies	\$ 18,476	18,476			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 23,199	23,199			
2. Cellular Phones	\$ 2,249	2,249			
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$				
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (Specify) See Attached Schedule	\$ 808	808			
3. Resident Day User Fee	\$ 368,691	368,691			
Subtotal	\$ 1,570,936	1,570,936			

* 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**

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
Union Health & Welfare	\$ (104)	\$ -	\$ -
Union Health & Welfare	\$ (40)	\$ -	\$ -
Union Health & Welfare	\$ (129)	\$ -	\$ -
Union Health & Welfare	\$ (64)	\$ -	\$ -
Union Health & Welfare	\$ (245)	\$ -	\$ -
Union Health & Welfare	\$ (379)	\$ -	\$ -
Union Health & Welfare	\$ 270,208	\$ -	\$ -
Union Health & Welfare	\$ 9,666	\$ -	\$ -
Benefit Allocations	\$ 403	\$ -	\$ -
Benefit Allocations	\$ 135	\$ -	\$ -
Benefit Allocations	\$ (135)	\$ -	\$ -
Total	\$ 279,315	\$ -	\$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Sales Tax	\$ 808	\$ -	\$ -
Sales Tax	\$ -	\$ -	\$ -
	0	\$ -	\$ -
	0	\$ -	\$ -
Total	\$ 808	\$ -	\$ -

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

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2020		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
<i>Subtotals Brought Forward:</i>		1,570,936	1,570,936		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	3,224	3,224		
5. Education Expenses Related to Seminars and Conventions	\$	113	113		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	207	207		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	8,293	8,293		
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	\$	2,373	2,373		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	6,557	6,557		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$	111	111		
10. Contributions*** See Attached Schedule	\$	1,111	1,111		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	26,552	26,552		
12. Administrative Management Services**	\$	494,405	494,405		
13. Other (<i>Specify</i>) See Attached Schedule	\$	33,396	33,396		
<i>C-14 Total Administrative & General Expenditures</i>	\$	2,147,278	2,147,278		

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Advertising	\$ 1,778	\$ -	\$ -
Marketing Expense	\$ 2,269	\$ -	\$ -
Marketing Exp- Corporate Spend	\$ 4,245	\$ -	\$ -
Marketing Exp- Corporate Spend	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
Total Other Advertising	\$ 8,293	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Licenses & Certifications	\$ 6,557	\$ -	\$ -
Dues to Chamber of Commerce	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
Total Dues	\$ 6,557	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Contributions	\$ -	\$ -	\$ -
Political Contributions	\$ 1,111	\$ -	\$ -
Total Contributions	0	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Service Charges	\$ 4,813	\$ -	\$ -
Collection Fees	\$ 5,023	self-disallowed	\$ -
Education Expense	\$ 260	\$ -	\$ -
Employee Physicals	\$ 4,996	\$ -	\$ -
Employee Relations	\$ 4,205	\$ -	\$ -
Printing	\$ 310	\$ -	\$ -
Training Expense	\$ 190	\$ -	\$ -
Fines & Penalties	\$ -	self-disallowed	\$ -
Miscellaneous	\$ 578	\$ -	\$ -
Rental Expense	\$ 179	\$ -	\$ -
Accrued Expense Estimation	\$ 607	self-disallowed	\$ -
Landlord Operating Taxes	\$ 600	\$ -	\$ -
State Tax Annual Report Filing	\$ -	\$ -	\$ -
Recruiting Fees	\$ -	\$ -	\$ -
Recruiting Fees	\$ 10,949	\$ -	\$ -
Interest Expense	\$ -	\$ -	\$ -
Non-recurring Charges	\$ -	\$ -	\$ -
Education Expense	\$ 440	\$ -	\$ -
Uniforms	\$ 247	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
Total Other Administrative and General	\$ 33,396	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2020	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Genesis Administrative Services LLC, 101 East St., Kennett Square, PA 19348	396,264	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12

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

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

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2020		Page 18 of 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 116,767	116,767		
2. Non-Food Supplies	\$ 26,486	26,486		
3. Other (Specify) _____	\$ 1,625	1,625		
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ 655,553	655,553		
c. Other (Specify) _____	\$			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 800,430	800,430		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*				
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				
H. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
K. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2020		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. \$	4,074	4,074	
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. \$	10,582	10,582	
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$	152,580	152,580	
c. Other (Specify)	\$			
3D. Total Laundry Expenditures (3a + b + c)	\$	167,236	167,236	
3E. Laundry Questionnaire				
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
K. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

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

All allocations should add to total recorded in 3D.

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

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

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2020		Page 20	of 37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 12,713	12,713		
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)					
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel				
	Amt.	\$ 292,796	292,796		
C. Other (<i>Specify</i>)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	305,509	305,509		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	316,785	316,785		
b. Medicine Cabinet Drugs	\$	(15,282)	(15,282)		
c. Medical and Therapeutic Supplies	\$	169,450	169,450		
d. Ambulance/Limousine***	\$	3,155	3,155		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	3,443	3,443		
f. X-rays and Related Radiological Procedures***	\$	16,899	16,899		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	116,963	116,963		
i. Recreation	\$	18,008	18,008		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	76,133	76,133		
5M. Total Resident Care Expenditures (5a - 5j)	\$	705,556	705,556		

* 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)
Incontinency	\$ 26,719	\$ -	\$ -
Advertising-Help Wanted	\$ (100)	\$ -	\$ -
Advertising-Help Wanted	\$ 1,690	\$ -	\$ -
Books, Dues & Subscriptions	\$ 126	\$ -	\$ -
Education Expense	\$ 597	\$ -	\$ -
Supplies	\$ 539	\$ -	\$ -
Supplies	\$ 5,287	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -
Office Supplies	\$ 502	\$ -	\$ -
Office Supplies	\$ 156	\$ -	\$ -
Office Supplies	\$ -	\$ -	\$ -
Training Expense	\$ -	\$ -	\$ -
Rental Expense	\$ 255	\$ -	\$ -
Rental Expense	\$ 7,508	\$ -	\$ -
Consolidated Billing	\$ 31,909	\$ -	\$ -
Tuition Reimbursement	\$ -	\$ -	\$ -
Tuition Reimbursement	\$ -	\$ -	\$ -
Tuition Reimbursement	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
Licenses & Certifications	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -
Office Supplies	\$ 11	\$ -	\$ -
T&E-Lodging/Transportation	\$ 933	\$ -	\$ -
Total Other Resident Care	\$ 76,133	\$ -	\$ -

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

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

** Refer to Page 4 for definition of related.

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

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

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2020			Page 22 37
Item	Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 205,351	205,351			
b. Heat	\$ 31,374	31,374			
c. Light & Power	\$ 141,794	141,794			
d. Water	\$ 43,666	43,666			
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$				
f. Other (<i>itemize</i>)	\$				
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 422,185	422,185			
7. Depreciation (<i>complete schedule page 23*</i>)					
a. Land Improvements	\$ 7,626	7,626			
b. Building & Building Improvements	\$ (14,239)	(14,239)			
c. Non-Movable Equipment	\$				
d. Movable Equipment	\$ 275	275			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ (6,338)	(6,338)			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)					
a. Organization Expense	\$				
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$				
d. Other (<i>Specify</i>)	\$				
*8e. Total Amortization Costs (8a + b + c + d)	\$				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 183,700	183,700			
10. Property Taxes					
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$ 177,284	177,284			
c. Personal property taxes	\$				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 354,646	354,646			

* 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

Depreciation Schedule

Name of Facility Willows Care and Rehabilitation Center				License No. 2202-C			Report for Year Ended 9/30/2020				Page 23	of 37	
Property Item				Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals		
A. Land Improvements													
1. Acquired prior to this report period				70,450		70,450	1,513	S/L	Various	7,434			
2. Disposals (attach schedule)				(168)		(168)							
3. Acquired during this report period (attach schedule)				2,303		2,303				192			
A-4. Subtotal											7,626		
B. Building and Building Improvements													
1. Acquired prior to this report period				30,856		30,856	21,550	S/L	Various	(16,946)			
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)				41,903		41,903				2,707			
B-4. Subtotal											(14,239)		
C. Non-Movable Equipment													
1. Acquired prior to this report period								S/L	Various				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal													
	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.													
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period					21,755		21,755	6,999	S/L	Various			
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)					20,795		20,795						
D-3. Subtotal											1,618		
E. Total Depreciation											275		
											(6,338)		

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
12/31/2019	New Fence installation	\$ 2,303	9	\$ 192
1/0/1900		1/0/1900	\$ -	\$ -
1/0/1900		1/0/1900	\$ -	\$ -
1/0/1900		1/0/1900	\$ -	\$ -
		\$ -	\$ -	\$ -
Total additions for Land Improvements		\$ 2,303		\$ 192
Deletions:				
10/1/2019	Reversal September 2019 DSSI Accrual	\$ (168)	\$ -	\$ -
Total deletions for Land Improvements		\$ (168)		\$ -
Net Land Improvements				

^{**}Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

**Ties to Page 23, Line B3

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

Schedule of Non-Movable Equipment Acquired during this report period

¹¹Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

*Ties to Page 23, Lines D2

**Ties to Page 23, Line D2

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

Amortization Schedule*

Name of Facility Willows Care and Rehabilitation Center			License No. 2202-C		Report for Year Ended 9/30/2020			Page 24		of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals	
	Month	Year								
A. Organization Expense										
1.										
2.										
3.										
A-4. Subtotal										
B. Mortgage Expense										
1.										
2.										
3.										
B-4. Subtotal										
C. Leasehold Improvements and Other										
1. Acquired prior to this report period										
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.

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

Name of Facility Willows Care and Rehabilitation Cent	License No. 2202-C	Report for Year Ended 9/30/2020	Page 25	of 37
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11. Property Questionnaire

Part A

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

Yes

No

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

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

Description	Total			
1. Date Land Purchased	n/a			
2. Date Structure Completed	n/a			
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	n/a			
b. Building	n/a			

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
GMF-CT	Facility Lease	12/21/2018-12	10 years	183,700
650 Madison Avenue New York, NY 10022				

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

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

Name of Facility	License No.	Report for Year Ended 9/30/2020			Page 26	of 37
Item		Total	CCNH	RHNS	(Specify)	
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
2. Second Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
3. Third Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
4. Fourth Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount	\$					
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)	\$					

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended 9/30/2020			Page 27	of 37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment	\$					
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)	\$					
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)	\$					
12. D. Other Interest Expense (Specify)	\$					
13. Total All Interest Expense (12B7 + 12C3 + 12D)	\$					
14. Insurance						
a. Insurance on Property (buildings only)	\$	13,908	13,908			
b. Insurance on Automobiles	\$					
c. Insurance other than Property (as specified above)						
1. Umbrella (<i>Blanket Coverage</i>)	\$	157,252	157,252			
2. Fire and Extended Coverage	\$					
3. Other (Specify)	\$					
14d. Total Insurance Expenditures (14a + b + c)	\$	171,160	171,160			
15. Total All Expenditures (A-13 thru C-14)	\$	10,715,987	10,715,987			

D. Adjustments to Statement of Expenditures

Name of Facility Willows Care and Rehabilitation Center			License No. 2202-C	Report for Year Ended 9/30/2020		Page 28	of 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	\$ 46,460	46,460		
Page 13 - Professional Fees							
5.	13	B-8-c	Resident Care Physicians **	\$			
6.		B-10	Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 964,118	964,118		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1-c	Bad Debts	\$ 105,088	105,088		
10.			Accounting	\$			
10a.			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 *	\$ 8,293	8,293		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 1,111	1,111		
21.			Unallowable Management Fees	\$ 98,141	98,141		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 18,067	18,067		
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)			\$ 1,241,279	1,241,279			

* 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	\$ 46,460	\$ -	\$ -
0	0		0	\$ -	\$ -
0	0		0	\$ -	\$ -
0	0		0	\$ -	\$ -
0	0		0	\$ -	\$ -
0	0		0	\$ -	\$ -
0	0		0	\$ -	\$ -
Total Other Salaries Adjustment			\$ 46,460	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	\$ 137,879	\$ -	\$ -
13	5	Rehabilitation Services	\$ 665,961	\$ -	\$ -
13	9	Speech Therapist	\$ 11,656	\$ -	\$ -
13	10	Occupational Therapist	\$ 144,964	\$ -	\$ -
13	12	Other	\$ -	\$ -	\$ -
13	12	Other	\$ -	\$ -	\$ -
13	12	Respiratory Purchased Servies	\$ 3,659	\$ -	\$ -
Total Other Fees Adjustments			\$ 964,118	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m-13	Collection Fees	\$ 5,023	\$ -	\$ -
16	m-13	Estimated Accrual	\$ 607	\$ -	\$ -
16	m-13	Non-recurring Charges	\$ -	\$ -	\$ -
16	m-13	Dues to Chamber of Commerce	\$ -	\$ -	\$ -
16	m-13	Penalty	\$ -	\$ -	\$ -
16	m-12		0	\$ -	\$ -
15	1-a-1	adj workers comp	\$ 12,438	\$ -	\$ -
Total Other A&G Adjustments			\$ 18,067	\$ -	\$ -

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

Name of Facility Willows Care and Rehabilitation Center				License No. 2202-C	Report for Year Ended 9/30/2020		Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)	
Subtotals Brought Forward				\$ 1,241,279	1,241,279			
Page 20 - Resident Care Supplies***								
27.	20	5-a-2	Prescription Drugs	\$ 316,785	316,785			
28.	20	5-d	Ambulance/Limousine	\$ 3,155	3,155			
29.	20	5-f	X-rays, etc	\$ 16,899	16,899			
30.	20	5-h	Laboratory	\$ 116,963	116,963			
31.			Medical Supplies	\$				
32.	20	5-e-2	Oxygen (non emergency)	\$ 3,443	3,443			
33.			Occupational Therapy	\$				
34.			Other - See Attached Schedule	\$ 44,704	44,704			
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ (126,119)	(126,119)			
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.			Other - Indirect	\$ 9,726	9,726			
43.			Interest Income on Account Rec.	\$				
44.			Other - Miscellaneous Administrative	\$ 103,602	103,602			
45.			Management Fees Direct	\$				
46.			Management Fees Indirect	\$				
47.			Other - Direct	\$				
Not For Profit Providers Only								
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$				
49.			Total Amount of Decrease (Items 1 - 48)	\$ 1,730,437	1,730,437			

*** 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.

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-j	Consolidated Billing	\$ 31,909	\$ -	\$ -
20	5-j	Respiratory Supplies	\$ 5,287	\$ -	\$ -
20	5-j	Respiratory Rental	\$ 7,508	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
Total Other Ancillary Costs			\$ 44,704	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Page 22	7a	Land Imp	\$ (6,716)	\$ -	\$ -
Page 22	7b	Bldg Imp	\$ (48,368)	\$ -	\$ -
Page 22	7c	Non Movable Equip	\$ (35,910)	\$ -	\$ -
Page 22	7d	Movable Equip	\$ (35,125)	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
Total Excess Movable Equipment Depreciation			\$ (126,119)	\$ -	\$ -

Schedule of Other Property Adjustments

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-i	Cable TV - Allowable \$3,600 Account#3005660130	\$ 9,726	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
Total Other Adjustments			\$ 9,726	\$ -	\$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14c1	General liability Insurance Adjust	\$ 103,602	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
Total Other Adjustments			\$ 103,602	\$ -	\$ -

Schedule of Other - Direct Adjustments

Schedule of Unallowable Building Interest

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended 9/30/2020			Page 30	of 37
Item		Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 6,993,231	6,993,231				
b. Medicaid Room and Board Contractual Allowance **	\$ (2,917,431)	(2,917,431)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 2,570,442	2,570,442				
b. Medicare Room and Board Contractual Allowance **	\$ (519,651)	(519,651)				
4. a. Private-Pay Residents and Other	\$ 2,857,708	2,857,708				
b. Private-Pay Room and Board Contractual Allowance **	\$ (1,291,415)	(1,291,415)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 137,347	137,347				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (27,767)	(27,767)				
c. Prescription Drugs - Non-Medicare	\$ 191,678	191,678				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (86,385)	(86,385)				
2. a. Medical Supplies - Medicare	\$ 5,623	5,623				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (1,137)	(1,137)				
c. Medical Supplies - Non-Medicare	\$ 72	72				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (31)	(31)				
3. a. Physical Therapy - Medicare	\$ 544,673	544,673				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (110,113)	(110,113)				
c. Physical Therapy - Non-Medicare	\$ 563,275	563,275				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (252,929)	(252,929)				
4. a. Speech Therapy - Medicare	\$ 31,931	31,931				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (6,455)	(6,455)				
c. Speech Therapy - Non-Medicare	\$ 41,692	41,692				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (18,661)	(18,661)				
5. a. Occupational Therapy - Medicare	\$ 630,771	630,771				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (127,519)	(127,519)				
c. Occupational Therapy - Non-Medicare	\$ 626,103	626,103				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (281,429)	(281,429)				
6. a. Other (<i>Specify</i>) - Medicare	\$ 67,615	67,615				
b. Other (<i>Specify</i>) - Non-Medicare	\$ 31,647	31,647				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 9,652,885	9,652,885				
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 (<i>Specify</i>)	\$ 138	138				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 479,128	479,128				
V. Total Other Revenue (1 thru 8)	\$ 479,266	479,266				
VI. Total All Revenue (III +V)	\$ 10,132,151	10,132,151				

* 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	X-Ray	\$ 10,485	\$ - \$ -
II-6-a	Medicare	Laboratory	\$ 56,561	\$ - \$ -
II-6-a	Medicare	Respiratory Therap	\$ 961	\$ - \$ -
II-6-a	Medicare	Nursing Treatment	\$ -	\$ - \$ -
II-6-a	Medicare	Audiology	\$ 184	\$ - \$ -
II-6-a	Medicare	Incontinency	\$ -	\$ - \$ -
II-6-a	Medicare	Oxygen & Supplie	\$ -	\$ - \$ -
II-6-a	Medicare	Physician Visit	\$ 153	\$ - \$ -
II-6-a	Medicare	Ambulance	\$ 12,756	\$ - \$ -
II-6-a	Medicare	Flu Shot	\$ 3,648	\$ - \$ -
II-6-a	Medicare Contractual	X-Ray	\$ (2,120)	\$ - \$ -
II-6-a	Medicare Contractual	Laboratory	\$ (11,435)	\$ - \$ -
II-6-a	Medicare Contractual	Respiratory Therap	\$ (194)	\$ - \$ -
II-6-a	Medicare Contractual	Nursing Treatment	\$ -	\$ - \$ -
II-6-a	Medicare Contractual	Audiology	\$ (37)	\$ - \$ -
II-6-a	Medicare Contractual	Incontinency	\$ -	\$ - \$ -
II-6-a	Medicare Contractual	Oxygen & Supplie	\$ -	\$ - \$ -
II-6-a	Medicare Contractual	Physician Visit	\$ (31)	\$ - \$ -
II-6-a	Medicare Contractual	Ambulance	\$ (2,579)	\$ - \$ -
II-6-a	Medicare Contractual	Flu Shot	\$ (737)	\$ - \$ -
		0	\$ 0	\$ - \$ -
Total Other Resident Revenue - Medicare		\$ 67,615	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
II-6-b	Medicaid	X-Ray	\$ 156	\$ - \$ -
II-6-b	Medicaid	Laboratory	\$ 277	\$ - \$ -
II-6-b	Medicaid	Respiratory Therap	\$ 374	\$ - \$ -
II-6-b	Medicaid	Nursing Treatment	\$ -	\$ - \$ -
II-6-b	Medicaid	Audiology	\$ -	\$ - \$ -
II-6-b	Medicaid	Incontinency	\$ -	\$ - \$ -
II-6-b	Medicaid	Oxygen & Supplie	\$ -	\$ - \$ -
II-6-b	Medicaid	Physician Visit	\$ -	\$ - \$ -
II-6-b	Medicaid	Ambulance	\$ -	\$ - \$ -
II-6-b	Medicaid	Flu Shot	\$ -	\$ - \$ -
II-6-b	Contractuals-Medicaid	X-Ray	\$ (65)	\$ - \$ -
II-6-b	Contractuals-Medicaid	Laboratory	\$ (116)	\$ - \$ -
II-6-b	Contractuals-Medicaid	Respiratory Therap	\$ (156)	\$ - \$ -
II-6-b	Contractuals-Medicaid	Nursing Treatment	\$ -	\$ - \$ -
II-6-b	Contractuals-Medicaid	Audiology	\$ -	\$ - \$ -
II-6-b	Contractuals-Medicaid	Incontinency	\$ -	\$ - \$ -
II-6-b	Contractuals-Medicaid	Oxygen & Supplie	\$ -	\$ - \$ -
II-6-b	Contractuals-Medicaid	Physician Visit	\$ -	\$ - \$ -
II-6-b	Contractuals-Medicaid	Ambulance	\$ -	\$ - \$ -
II-6-b	Contractuals-Medicaid	Flu Shot	\$ -	\$ - \$ -
II-6-b	Non-Medicaid	X-Ray	\$ 6,295	\$ - \$ -
II-6-b	Non-Medicaid	Laboratory	\$ 43,231	\$ - \$ -
II-6-b	Non-Medicaid	Respiratory Therap	\$ 1,679	\$ - \$ -
II-6-b	Non-Medicaid	Nursing Treatment	\$ -	\$ - \$ -
II-6-b	Non-Medicaid	Audiology	\$ -	\$ - \$ -
II-6-b	Non-Medicaid	Incontinency	\$ -	\$ - \$ -
II-6-b	Non-Medicaid	Oxygen & Supplie	\$ -	\$ - \$ -
II-6-b	Non-Medicaid	Physician Visit	\$ -	\$ - \$ -
II-6-b	Non-Medicaid	Ambulance	\$ -	\$ - \$ -
II-6-b	Non-Medicaid	Flu Shot	\$ -	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	X-Ray	\$ (2,845)	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	Laboratory	\$ (19,336)	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	Respiratory Therap	\$ (759)	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	Nursing Treatment	\$ -	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	Audiology	\$ -	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	Incontinency	\$ -	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	Oxygen & Supplie	\$ -	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	Physician Visit	\$ -	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	Ambulance	\$ 5,677	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	Flu Shot	\$ -	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	Capitation Contrac	\$ -	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	X-Ray	\$ (2,845)	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	Laboratory	\$ (19,336)	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	Respiratory Therap	\$ (759)	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	Nursing Treatment	\$ -	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	Audiology	\$ -	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	Incontinency	\$ -	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	Oxygen & Supplie	\$ -	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	Physician Visit	\$ -	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	Ambulance	\$ (2,565)	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	Flu Shot	\$ -	\$ - \$ -
II-6-b	Contractuals-Non-Medicaid	Capitation Contrac	\$ -	\$ - \$ -
		0	\$ 0	\$ - \$ -
Total Other Resident Revenue		\$ 31,647	\$ -	\$ -

Interest Income

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
IV-5	Interest On Overdue Accounts	0	\$ 138	\$ -	\$ -
Total Interest Income		\$ 138	\$ -	\$ -	

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
IV-8	Federal Stimulus 1	0	\$ 180,760	\$ - \$ -
IV-8	Federal Stimulus 2	0	\$ 22,020	\$ - \$ -
IV-8	Federal Stimulus 3	0	\$ 275,000	\$ - \$ -
IV-8	MEDICAL RECORDS 630530MRC	0	\$ 263	\$ - \$ -
IV-8	Rehab Settlement	0	\$ 600	\$ - \$ -
IV-8	Rehab Settlement	0	\$ 375	\$ - \$ -
IV-8	Telehealth Facility Fee	0	\$ 110	\$ - \$ -
		0	\$ 0	\$ - \$ -
Total Other Revenue		\$ 479,128	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of	
Willows Care and Rehabilitation Center	2202-C	9/30/2020	31	37	
Account				Amount	
Assets					
A. Current Assets					
1. Cash (<i>on hand and in banks</i>)				\$ 4,457	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				\$ 1,310,035	
3. Other Accounts Receivable (Excluding Owners or Related Parties)				\$ 54,823	
4. Inventories				\$ 38,141	
5. Prepaid Expenses				\$ 39,966	
a. _____					
b. _____					
c. _____					
d. See Schedule				39,966	
6. Interest Receivable				\$	
7. Medicare Final Settlement Receivable				\$	
8. Other Current Assets (<i>itemize</i>)				\$	

See Schedule					
A-9. Total Current Assets (Lines A1 thru 8)				\$ 1,447,422	
B. Fixed Assets				\$	
1. Land				\$	
2. Land Improvements	*Historical Cost	72,586	\$	63,446	
	Accum. Depreciation	9,140		Net	
3. Buildings	*Historical Cost	72,760	\$	65,449	
	Accum. Depreciation	7,311		Net	
4. Leasehold Improvements	*Historical Cost	_____	\$		
	Accum. Depreciation	_____		Net	
5. Non-Movable Equipment	*Historical Cost	_____	\$		
	Accum. Depreciation	_____		Net	
6. Movable Equipment	*Historical Cost	42,550	\$	35,276	
	Accum. Depreciation	7,274		Net	
7. Motor Vehicles	*Historical Cost	_____	\$		
	Accum. Depreciation	_____		Net	
8. Minor Equipment-Not Depreciable				\$	
9. Other Fixed Assets (<i>itemize</i>)				\$	
See Schedule					
B-10. Total Fixed Assets (Lines B1 thru 9)				\$ 164,171	

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
30	A5	Prepaid Expenses	\$ -
30	A5	Prepaid Prop Taxes	\$ 31,970
30	A5	Prepaid Personal Property Tax	\$ 7,996
30	A5		
Total Prepaid Expenses			\$ 39,966

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

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

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
32	D7	ROU Bldg Asset-Oper Lease	
32	D7	AccumAmort-ROU Bldg OprLease	
Total Other Assets			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

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

Page Ref	Line Ref	Description	
33	A12		
33	A12	Accr Gross Rec Tax-FY11	\$ 2,640
33	A12	Accr Gross Rec Tax-FY12	\$ 2,400
33	A12	Accr Gross Rec Tax-FY13	\$ 2,400
33	A12	Accr Gross Rec Tax-FY14	\$ 2,400
33	A12	Accr Gross Rec Tax-FY15	\$ 2,400
33	A12	Accr Gross Rec Tax-FY16	\$ 2,400
33	A12	Accr Gross Rec Tax-FY17	\$ 2,400
33	A12	Accr Gross Rec Tax-FY18	\$ 4,800
33	A12	Accr Sales and Use Tax - FY18	95
Total Other Current Liabilities (Itemize)			\$ 21,935

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

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

G. Balance Sheet (cont'd)

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2020	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	1,611,593
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements	*Historical Cost Accum. Depreciation	Net	\$	
3. Buildings	*Historical Cost Accum. Depreciation	Net	\$	
4. Non-Movable Equipment	*Historical Cost Accum. Depreciation	Net	\$	
5. Movable Equipment	*Historical Cost Accum. Depreciation	Net	\$	
6. Motor Vehicles	*Historical Cost Accum. Depreciation	Net	\$	
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense	*Historical Cost Accum. Depreciation	Net	\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	(6,116,011)
I/C Due to/Due From Owned	(6,116,011)			
I/C Due to/Due From Multicare				
See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	(6,116,011)
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	(4,504,418)

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
		9/30/2020	33 37
Account		Amount	
Liabilities			
A. Current Liabilities			
1. Trade Accounts Payable		\$ 411,153	
2. Notes Payable (<i>itemize</i>)		\$	
See Schedule			
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)		\$	
Name of Lender	Purpose	Amount	Date Due
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)		\$ 218,762	
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)		\$	
6. Accrued Payroll Taxes Payable		\$ 844	
7. Medicare Final Settlement Payable		\$	
8. Medicare Current Financing Payable		\$	
9. Mortgage Payable (<i>Current Portion</i>)		\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)		\$	
11. Accrued Income Taxes*		\$	
12. Other Current Liabilities (<i>itemize</i>)		\$ 1,001,127	
Accr Exp Water and Sewer		3,121 Deferred Revenue	153,298
Accr Exp Gas		469 A/R Credit Gross Up Lia	91,669
Accr Exp Electricity		6,796 Accrued Provider/Bed Ta	83,849
Accr Exp Nursing Purchased Ser		639,990 See Schedule	21,935
A-13. Total Current Liabilities (Lines A1 thru 12)		\$	1,631,886

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2020	Page 34	of 37
Account				Amount
Total Brought Forward:				1,631,886
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ 1,698,015
LT Debt-Financing Obligation				1,698,015
Escheatable Funds				
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 1,698,015
C. Total All Liabilities (Lines A-13 + B-5)				\$ 3,329,901

G. Balance Sheet (cont'd)

Reserves and Net Worth

Name of Facility Willows Care and Rehabilitation Cent	License No. 2202-C	Report for Year Ended 9/30/2020	Page 35	of 37
Account				Amount
A. Reserves				
1. Reserve for value of leased land				\$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized				\$
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)				\$
4. Reserve for leasehold real properties on which fair rental value is based				\$
5. Reserve for funds set aside as donor restricted				\$
6. Total Reserves				\$
B. Net Worth				
1. Owner's Capital				\$
2. Capital Stock				\$
3. Paid-in Surplus				\$
4. Treasury Stock				\$
5. Cumulated Earnings				\$ (7,250,485)
6. Gain or Loss for Period	10/1/2019	thru	9/30/2020	\$ (583,836)
7. Total Net Worth				\$ (7,834,321)
C. Total Reserves and Net Worth				\$ (7,834,321)
D. Total Liabilities, Reserves, and Net Worth				\$ (4,504,420)

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Willows Care and Rehabilitation Center	2202-C	9/30/2020	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2019				\$ (7,250,485)		
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 10,132,151		
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 10,715,987		
D. Net Income or Deficit				\$ (583,836)		
E. Balance				\$ (7,834,321)		
F. Additions						
1. Additional Capital Contributed (<i>itemize</i>)						
2. Other (<i>itemize</i>)						
F-3. Total Additions				\$		
G. Deductions						
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)				\$		
Name and Address (No., City, State, Zip)		Title	Amount			
2. Other Withdrawings (<i>Specify</i>)				\$		
Purpose		Amount				
3. Total Deductions				\$		
H. Balance at End of Period				\$ (7,834,321)		

I. Preparer's/Reviewer's Certification

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2020	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		

Preparer/Reviewer Certification

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
Printed Name of Preparer		
Thomas Farnan		
Address Address 200 Brickstone Square, Andover, MA 01810		Phone Number 978-247-5029
Contacted Person Regarding Additional Information Needed Regarding This Report Thomas Farnan		Phone Number 978-247-5029
Contact Email Address thomas.farnan@geneshcc.com		