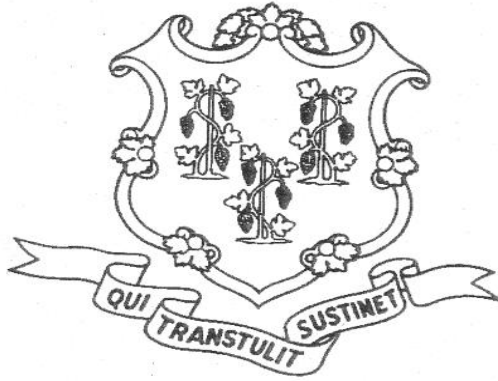


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2018

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 type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018

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

Medicaid Provider Numbers:	CCNH 220559	RHNS	ICF-IID
----------------------------	----------------	------	---------

For Department Use Only

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

Table of Contents

General Information - Administrator's/Owner's Certification	1
General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
General Information and Questionnaire - Type of Facility - Organization Structure	2
General Information and Questionnaire - Partners/Members	3
General Information and Questionnaire - Corporate Owners	3A
General Information and Questionnaire - Individual Proprietorship	3B
General Information and Questionnaire - Related Parties	4
General Information and Questionnaire - Basis for Allocation of Costs	5
General Information and Questionnaire - Leases	6
General Information and Questionnaire - Accounting Basis	7
Schedule of Resident Statistics	8
Schedule of Resident Statistics (Cont'd)	9
A. Report of Expenditures - Salaries & Wages	10
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B. Report of Expenditures - Professional Fees	13
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C. Expenditures Other than Salaries - Administrative and General	15
C. Expenditures Other than Salaries (Cont'd) - Administrative and General	16
Schedule C-1 - Management Services	17
C. Expenditures Other than Salaries (Cont'd) - Dietary	18
C. Expenditures Other than Salaries (Cont'd) - Laundry	19
C. Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
Depreciation Schedule	23
Amortization Schedule	24
C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C. Expenditures Other than Salaries (Cont'd) - Interest	26
C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D. Adjustments to Statement of Expenditures	28
D. Adjustments to Statement of Expenditures (Cont'd)	29
F. Statement of Revenue	30
G. Balance Sheet	31
G. Balance Sheet (Cont'd)	32
G. Balance Sheet (Cont'd)	33
G. Balance Sheet (Cont'd)	34
G. Balance Sheet (Cont'd) - Reserves and Net Worth	35
H. Changes in Total Net Worth	36
I. Preparer's/Reviewer's Certification	37

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2018	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Willows Care and Rehabilitation Center [facility name], for the cost report period beginning October 1, 2017 and ending September 30, 2018, 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)			Printed Name (Owner)		
Peter Mongillo			Keith Davis, V.P. of Reimb., Genesis Healthcare		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires	
				/ /	
Address of Notary Public					

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Willows Care and Rehabilitation Center		Period Covered:	From 10/1/2017	To 9/30/2018
Address of Facility 225 Amity Road, Woodbridge, CT 06525				
Report Prepared By Thomas Farnan		Phone Number 978-247-5029	Date 12/21/2017	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$	3,411,486	3,411,486	
5. All other wages paid	\$	588,095	588,095	
6. Total Wages Paid	\$	3,999,580	3,999,580	
7. Total salaries paid	\$	232,617	232,617	
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$	4,232,197	4,232,197	

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 9/30/2018	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:	CCNH 2202-C	RHNS	(Specify)	Medicare Provider No. 07-5331
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Peter Mongillo		Nursing Home Administrator's License No.:	1401/1860	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

General Information and Questionnaire Related Parties*

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2018	Page 4	of 37
--	-----------------------	------------------------------------	-----------	----------

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Genesis Healthcare	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Home Office	Pg 16/m12	397,618	397,618
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	63%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	1,138,381	1,138,381
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	<input type="radio"/>	<input checked="" type="radio"/>	50%	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	40,777	40,777
Career Staffing	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	91%	Outside Agency	Pg 13/B11 pg 10-12, 15		
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	<input checked="" type="radio"/>	<input type="radio"/>	40%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E2	5,969	5,969
Genesis Healthcare	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Insurance	Pg 27/14	161,339	161,339
Genesis Healthcare	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Capital Interest	Page 17, page 26-12A	40,858	40,858
		<input type="radio"/>	<input type="radio"/>					

* Use additional sheets if necessary.

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

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2018	Page 5	of 37
--	-----------------------	------------------------------------	-----------	----------

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

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

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

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

General Information and Questionnaire 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 Willows Care and Rehabilitation Center			License No. 2202-C		Report for Year Ended 9/30/2018		Page 6	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes <input type="radio"/> 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.

Schedule of Resident Statistics

Name of Facility Willows Care and Rehabilitation Center			License No. 2202-C		Report for Year Ended 9/30/2018				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													
A. On last day of PREVIOUS report period	90	90			90	90			90	90			
B. On last day of THIS report period	90	90			90	90			90	90			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	85	85			85	85			79	79			
B. As of midnight of THIS report period	85	85			79	79			85	85			
3. Total Number of Days Care Provided During Period													
A. Medicare	5,430	5,430			4,065	4,065			1,365	1,365			
B. Medicaid (Conn.)	18,453	18,453			13,726	13,726			4,727	4,727			
C. Medicaid (other states)													
D. Private Pay	1,557	1,557			1,292	1,292			265	265			
E. State SSI for RCH													
F. Other (Specify)	4,485	4,485			3,377	3,377			1,108	1,108			
G. Total Care Days During Period (3A thru F)	29,925	29,925			22,460	22,460			7,465	7,465			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days	30	30			30	30							
B. Other Bed Reserve Days	7	7			7	7							
5. Total Resident Days (3G + 4A + 4B)	29,962	29,962			22,497	22,497			7,465	7,465			

Schedule of Resident Statistics (Cont'd)

Name of Facility Willows Care and Rehabilitation Center			License No. 2202-C			Report for Year Ended 9/30/2018			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 (1)	RHNS (2)	(Specify) (3)	Lost			Gained			CCNH	RHNS	(Specify)	
				(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	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-IID				
No. of Residents	20		50		15								
Per Diem Rate													
a. One bed rm.													
b. Two bed rms.	640.67		242.58		510.57								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									2,512	2,512			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									215	215			
C. Other									25,993	25,993			
D. Total Physical Therapy Treatments									28,720	28,720			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									132	132			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									6	6			
C. Other									1,012	1,012			
D. Total Speech Therapy Treatments									1,150	1,150			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									2,979	2,979			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									160	160			
C. Other									26,514	26,514			
D. Total Occupational Therapy Treatments									29,653	29,653			

Report of Expenditures - Salaries & Wages

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2018	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	121,859	2,086				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	1,215	34				
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	179,304	8,390				
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	66,614	2,083				
b. Other Maintenance Workers	29,911	1,625				
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	109,543	2,080				
b. RN						
1. Direct Care	870,379	22,458				
2. Administrative**	83,206	2,080				
c. LPN						
1. Direct Care	980,257	32,085				
2. Administrative**						
d. Aides and Attendants	1,400,688	70,282				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	128,551	5,245				
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	183,715	6,843				
n. Marketing						
o. Other (Specify) See Attached Schedule	76,956	3,786				
<i>A-13. Total Salary Expenditures</i>	4,232,197	159,077				

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

Name of Facility				License No.	Report for Year Ended			Page	of	
Willows Care and Rehabilitation Center				2202-C	9/30/2018			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
Willows Care and Rehabilitation Center				2202-C	9/30/2018			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	121,859				Management of Center	2,086	2			
Section IV - Assistant Administrators										
	1,215				Management of Center	34	3			

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Willows Care and Rehabilitation Center	2202-C	9/30/2018	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	6,766	46				
3. Pharmacist	7,368	150				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	1,021,793	13,997				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	71,557	379				
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	16,780	215				
b. Other						
10. Occupational Therapist						
a. Resident Care	104,084	1,426				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care	141	2				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	3,760					
B-13 Total Fees Paid in Lieu of Salaries	1,232,247	16,216				

* 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.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2018	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 216,447	216,447		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 49,221	49,221		
4. Social Security (F.I.C.A.)	\$ 314,798	314,798		
5. Health Insurance	\$ 233,486	233,486		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$			
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$ 281,350	281,350		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 57,294	57,294		
d. Accounting and Auditing	\$			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 43,099	43,099		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 21,839	21,839		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 21,595	21,595		
2. Cellular Phones	\$ 1,124	1,124		
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 (<i>Specify</i>) See Attached Schedule	\$ 689	689		
3. Resident Day User Fee	\$ 441,273	441,273		
Subtotal	\$ 1,682,215	1,682,215		

* 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**

Willows Care and Rehabilitation Center
9/30/2018

Attachment Page 15

Schedule of Other Employee Benefits

Description		CCNH	RHNS	(Specify)
3225520020	Union Health & Welfa	270,625.00	-	
5035520020	Union Health & Welfa	10,725.00	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
Total		\$ 281,350	\$ -	\$ -

0

Schedule of Other Taxes

Description		CCNH	RHNS	(Specify)
1020640110	Sales Tax	\$ 689	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -		
Total		\$ 689	\$ -	\$ -

0

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

Name of Facility	License No.	Report for Year Ended		Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2018		16	37
Item	Total	CCNH	RHNS	(Specify)	
<i>Subtotals Brought Forward:</i>	1,682,215	1,682,215			
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 280	280			
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 1,065	1,065			
5. Education Expenses Related to Seminars and Conventions	\$ 1,914	1,914			
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>)	\$				
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 14,207	14,207			
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	\$ 2,774	2,774			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 8,274	8,274			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 160	160			
10. Contributions*** See Attached Schedule	\$ 1,199	1,199			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 762	762			
12. Administrative Management Services**	\$ 427,461	427,461			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 28,816	28,816			
<i>C-14 Total Administrative & General Expenditures</i>	\$ 2,169,126	2,169,126			

* 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)
1020630020	Advertising	3,059.23	0	0
1020630330	Marketing Expense	8,532.55	0	0
1020630331	Marketing Exp- Corpora	2,615.57	0	0
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
Total Other Advertising		\$ 14,207	\$ -	\$ -
		\$ -		

Schedule of Dues

Description		CCNH	RHNS	(Specify)
1020630310	Licenses & Certificati	8,273.56	0	0

Total Dues		\$ 8,274	\$ -	\$ -
		\$ -		

Schedule of Contributions

Description		CCNH	RHNS	(Specify)
1020630135	Political Contributions	1199.16	0	0
-	-	-	-	-
-	-	-	-	-
Total Contributions		\$ 1,199	\$ -	\$ -
		\$ -		

Schedule of Other Administrative and General

Description		CCNH	RHNS	(Specify)
1020630060	Bank Service Charges	15334.13	0	0
1020630120	Collection Fees	6701.67	self-disallowed	0
1020630140	Education Expense	15.1	0	0
3165630140	Education Expense	-199.99	0	0
1020630180	Employee Physicals	2956.48	0	0
1020630200	Employee Relations	1752.7	0	0
1020630380	Printing	125.21	0	0
1020630610	Training Expense	400.36	0	0
1020640090	Miscellaneous	6	0	0
1020660080	Rental Expense	217.84	0	0
1020660990	Accrued Expense Esti	-893.62	self-disallowed	0
5095720090	Landlord Operating Ta	2400	0	0
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
Total Other Administrative and General		\$ 28,816	\$ -	\$ -

0

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Willows Care and Rehabilitation Center	2202-C	9/30/2018	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 Healthcare , 101 East St., Kennett Square, PA 19348	397,618	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Healthcare , 101 East St., Kennett Square, PA 19348	40,858	Capital Interest	pg 26 12-A-1

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2018	18	37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 128,106	128,106		
2. Non-Food Supplies	\$ 20,857	20,857		
3. Other (<i>Specify</i>) _____	\$ (332)	(332)		
b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	\$ 555,702	555,702		
c. Other (<i>Specify</i>) _____ Other Books, Dues & Subscriptions	\$			
2D. Total Dietary Expenditures (2a + b + c)	\$ 704,333	704,333		
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*				
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No				
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.				
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.				
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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
Willows Care and Rehabilitation Center		2202-C	9/30/2018	19	37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*		Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$	3,983	3,983	
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. \$	7,713	7,713	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	153,010	153,010	
c. Other (Specify) Other		\$			
3D. Total Laundry Expenditures (3a + b + c)		\$	164,706	164,706	
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
H. Did you receive revenue from employees?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
I. Where is the revenue received reported in the Cost Report?		(Page/Line Item)			
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K. Did you receive revenue from these people?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
L. Where is the revenue received reported in the Cost Report?		(Page/Line Item)			

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

All allocations should add to total recorded in 3E.

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

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

Name of Facility	License No.	Report for Year Ended	Page	of	
Willows Care and Rehabilitation Center	2202-C	9/30/2018	20	37	
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced				
a. In-House Care	by Personnel				
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt.	\$ 17,585	17,585		
b. Purchased Services (<i>by contract other than through Management Services</i>)	Sq. Ft. Serviced				
(<i>Complete Schedule C-2 att. Page 21</i>)	by Personnel				
c. Other (<i>Specify</i>)	Amt.	\$ 222,948	222,948		
4D. Total Housekeeping Expenditures (4a + b + c)		\$ 240,533	240,533		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy		\$			
2. Purchased from		\$ 361,261	361,261		
b. Medicine Cabinet Drugs		\$ 16,887	16,887		
c. Medical and Therapeutic Supplies		\$ 118,075	118,075		
d. Ambulance/Limousine***		\$ 16,357	16,357		
e. Oxygen					
1. For Emergency Use		\$			
2. Other***		\$ 5,592	5,592		
f. X-rays and Related Radiological Procedures***		\$ 19,341	19,341		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)		\$			
h. Laboratory***		\$ 45,255	45,255		
i. Recreation		\$ 25,357	25,357		
j. Direct Management Services*		\$			
k. Indirect Management Services*		\$			
l. Other (Specify)**** See Attached Schedule		\$ 61,075	61,075		
5M. Total Resident Care Expenditures (5a - 5l)		\$ 669,200	669,200		

* 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.

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

Name of Facility Willows Care and Rehabilitation Center			License No. 2202-C	Report for Year Ended 9/30/2018	Page 21	of 37				
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Laundry Purchased Services	153,010			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Housekeeping Purchased Services	220,667			20	4b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Dietary Purchased Servies	554,956			18	2b
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							

* 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).

Annual Report of Long-Term Care Facility

CSP-22 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended		Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2018		22	37
Item	Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 204,996	204,996			
b. Heat	\$ 49,314	49,314			
c. Light & Power	\$ 154,630	154,630			
d. Water	\$ 35,614	35,614			
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)	\$ 444,554	444,554			
7. Depreciation (<i>complete schedule page 23*</i>)					
a. Land Improvements	\$ 9,757	9,757			
b. Building & Building Improvements	\$ 33,328	33,328			
c. Non-Movable Equipment	\$ 26,699	26,699			
d. Movable Equipment	\$ 26,072	26,072			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 95,856	95,856			
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	\$ 1,199,106	1,199,106			
10. Property Taxes					
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$ 140,501	140,501			
c. Personal property taxes	\$				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,435,463	1,435,463			

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

Depreciation Schedule

Name of Facility Willows Care and Rehabilitation Center			License No. 2202-C		Report for Year Ended 9/30/2018			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	58,743		58,743	10,118	S/L	Various	9,757				
2. Disposals (attach schedule)											
3. Acquired during this report period (attach schedule)	(224)		(224)								
A-4. Subtotal								9,757			
B. Building and Building Improvements											
1. Acquired prior to this report period	182,055		182,055	30,621	S/L	Various	32,043				
2. Disposals (attach schedule)											
3. Acquired during this report period (attach schedule)	30,088		30,088				1,285				
B-4. Subtotal								33,328			
C. Non-Movable Equipment											
1. Acquired prior to this report period	261,665		261,665	106,561	S/L	Various	22,282				
2. Disposals (attach schedule)											
3. Acquired during this report period (attach schedule)	42,324		42,324				4,417				
C-4. Subtotal								26,699			
	Is a mileage logbook maintained?	Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year							
D. Movable Equipment											
1. Motor Vehicles (Specify name, model and year of each vehicle)											
a.								S/L	Various		
b.											
c.											
d.											
2. Movable Equipment											
a. Acquired prior to this report period					219,424	219,424	131,197	S/L	Various	21,452	
b. Disposals (attach schedule)											
c. Acquired during this report period (attach schedule)					43,141	43,141				4,619	
D-3. Subtotal											26,072
E. Total Depreciation											95,856

Willows Care and Rehabilitation Center
9/30/2018

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/1/2017	Reversed Sept 2017 Accrual	(925.00)		
9/30/2018	September 2018 DSSI Accrual	701.47		
Total additions for Land Improvements		(224)		- *
Deletions:				
		0		0
Total deletions for Land Improvements		\$ -		\$ - **

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
2/28/2018	Deposit for 5 fire rated doors	5,504.36	05 10	550.44
4/30/2018	Deposit for new fire doors	3,787.83	05 08	278.52
6/30/2018	Install Oak Fire Rated Doors	10,022.74	05 06	455.58
9/30/2018	Fire Door & installations	10,773.26	05 03	-
Total additions for Building Improvements		\$ 30,088		\$ 1,285 *

Deletions:		\$ -		\$ -	23 24
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:					
10/31/2017	2nd install pay on cooler/freezer	16,635.00	06 02	2,472.78	
12/31/2017	Deposit 28" multi temp trailer rental	100.00	06 00	12.50	
1/31/2018	Final install of cooler/freezer	5,125.00	05 11	577.46	
1/31/2018	Comco diesel trailer rental	200.00	05 11	22.54	
1/31/2018	Multi temp trailer rental	1,447.00	05 11	163.04	
1/31/2018	Misc shelving/accessories for non-movable equipment	2,470.85	05 11	278.40	
5/31/2018	Heat Pump	2,947.50	05 07	175.97	
5/31/2018	CoolPak (Cooling Tower)	4,463.47	05 07	266.47	
5/31/2018	Blower Section/New Shaft on Heat Pump	5,987.50	05 07	357.46	
7/31/2018	Heat Pump	2,947.50	05 05	90.69	
Total additions for Non-Movable Equipment		\$ 42,324		\$ 4,417	*
Deletions:					
Total deletions for Non-Movable Equipment		\$ -		\$ -	**

*Ties to Page 23, Line C3

0.00

\$ -

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
------------------	---------------------	------	-------------	--------------

Annual Report of Long-Term Care Facility

Amortization Schedule*

Name of Facility			License No.		Report for Year Ended			Page	of
Willows Care and Rehabilitation Center			2202-C		9/30/2018			24	37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
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 Center	License No. 2202-C	Report for Year Ended 9/30/2018	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*			<input type="radio"/> Yes <input checked="" type="radio"/> No		
*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.			If "Yes," complete Part B. If "No," complete Part C.		
Description		Total			
1. Date Land Purchased					
2. Date Structure Completed					
3. If NOT Original Owner, Date of Purchase					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity		90			
6. Square Footage					
7. Acquisition Cost					
a. Land					
b. Building					
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)					
b. Date Mortgage Obtained					
c. Interest Rate for the Cost Year					
d. Term of Mortgage (number of years)					
e. Amount of Principal Borrowed					
f. Principal balance outstanding as of _____					
Complete if Mortgage was Refinanced During Current Cost Year					
g. Type of Financing (e.g., fixed, variable)					
h. Date of Refinancing					
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed					
l. Principal Outstanding on Note Paid-Off					
Part C - Arms-Length Leases for Real Property Improvements Only					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	
SABRA, 101 Sun Ave. NE, Albuquerque, NM 87109	Facility Lease	11/15/10 - 6/30	127 months	1,199,106	

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Willows Care and Rehabilitation Cen		2202-C	9/30/2018		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$ 40,858	40,858		
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)			\$ 40,858	40,858		

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Willows Care and Rehabilitation C		2202-C		9/30/2018		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				40,858	40,858		
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)				\$ 40,858	40,858		
14. Insurance							
a. Insurance on Property (buildings only)				\$ 4,034	4,034		
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$ 157,305	157,305		
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. Total Insurance Expenditures (14a + b + c)				\$ 161,339	161,339		
15. Total All Expenditures (A-13 thru C-14)				\$ 11,494,556	11,494,556		

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center				2202-C	9/30/2018	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 36,634	36,634		
Page 13 - Professional Fees							
5.	13	B-8-c	Resident Care Physicians **	\$			
6.		B-10	Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 1,142,994	1,142,994		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1-c	Bad Debts	\$ 57,294	57,294		
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 *	\$ 14,207	14,207		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 1,199	1,199		
21.			Unallowable Management Fees	\$ 29,843	29,843		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 152,577	152,577		
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)				\$ 1,434,749	1,434,749		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	2	Administrator's salary disallowed	0	36634.10053	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
Total Other Salaries Adjustment			\$ 36,634	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	3120620020	98744.91	0
13	5	Rehabilitation Services	3195620020	923047.73	0
13	9	Speech Therapist	3170620020	16779.5	0
13	10	Occupational Therapist	3105620020	104083.86	0
13	12	Other	3010620020	0	0
13	12	Other	3015620020	0	0
13	12	Respiratory Purchased Servies	3155620020	338.25	0
				0	0
				0	0
				0	0
				0	0
				0	0
Total Other Fees Adjustments			\$ 1,142,994	\$ -	\$ -
			\$ -		

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m-13	Collection Fees	1020630120	6,701.67	-
16	m-8a	Chamber of Commerce	1020630310	-	-
16	m-13	Estimated Accrual	1020660990	(893.62)	-
16	m-13	Fines & Penalties	1020640080	-	-
16	m-13	Non-recurring Charges	7010800030	-	-
16	m12	0	-	-	-
15.00	1-a-1	adj workers comp	-	146,769.07	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
Total Other A&G Adjustments			\$ 152,577	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center				2202-C	9/30/2018	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,434,749	1,434,749		
Page 20 - Resident Care Supplies***							
27.	20	5-a-2	Prescription Drugs	\$ 361,261	361,261		
28.	20	5-d	Ambulance/Limousine	\$ 16,357	16,357		
29.	20	5-f	X-rays, etc	\$ 19,341	19,341		
30.	20	5-h	Laboratory	\$ 45,255	45,255		
31.			Medical Supplies	\$			
32.	20	5-e-2	Oxygen (non emergency)	\$ 5,592	5,592		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 25,568	25,568		
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.			Other - Indirect	\$ 14,693	14,693		
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ 112,679	112,679		
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)				\$ 2,035,496	2,035,496		

*** Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

Willows Care and Rehabilitation Center
9/30/2018

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description		CCNH	RHNS	(Specify)
20	5-j	Consolidated Billing		12170.93	3010610300	0
20	5-j	Respiratory Supplies		7084.64	3155630530	0
20	5-j	Respiratory Rental		6312.45	3155660080	0
0	0-Jan		0	0	0	0
0	0-Jan		0	0	0	0
0	0-Jan		0	0	0	0
0	0-Jan		0	0	0	0
0	0-Jan		0	0	0	0
0	0-Jan		0	0	0	0
0	0-Jan		0	0	0	0
0	0-Jan		0	0	0	0
Total Other Ancillary Costs				\$ 25,568	\$ -	\$ -
				\$ -		

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description		CCNH	RHNS	(Specify)
0	0-Jan		0	0	0	0
0	0-Jan		0	0	0	0
0	0-Jan		0	0	0	0
0	0-Jan		0	0	0	0
0	0-Jan		0	0	0	0
0	0-Jan		0	0	0	0
0	0-Jan		0	0	0	0
0	0-Jan		0	0	0	0
0	0-Jan		0	0	0	0
0	0-Jan		0	0	0	0
Total Excess Movable Equipment Depreciation				\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

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

Other - Miscellaneous- In Direct

Page Ref	Line Ref	Description	CCNH	RHNS	Attachment	Page 29
20	5-i	Cable TV	14,693.31	3005660130	allow	\$3600

Schedule of Other -Miscellaneous

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14 c1	General liability Insurance Adjust	112,679.29	0	0
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
Total Other Adjustments			\$ 112,679	\$ -	\$ -

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2018		30	37
Item	Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 9,449,574	9,449,574			
b. Medicaid Room and Board Contractual Allowance **	\$ (4,962,305)	(4,962,305)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 3,264,639	3,264,639			
b. Medicare Room and Board Contractual Allowance **	\$ (1,158,549)	(1,158,549)			
4. a. Private-Pay Residents and Other	\$ 3,536,822	3,536,822			
b. Private-Pay Room and Board Contractual Allowance **	\$ (1,531,395)	(1,531,395)			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 177,874	177,874			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (63,123)	(63,123)			
c. Prescription Drugs - Non-Medicare	\$ 207,532	207,532			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (90,980)	(90,980)			
2. a. Medical Supplies - Medicare	\$ (294)	(294)			
b. Medical Supplies - Medicare Contractual Allowance **	\$ 104	104			
c. Medical Supplies - Non-Medicare	\$ 356	356			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (154)	(154)			
3. a. Physical Therapy - Medicare	\$ 950,556	950,556			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (337,332)	(337,332)			
c. Physical Therapy - Non-Medicare	\$ 556,752	556,752			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (242,227)	(242,227)			
4. a. Speech Therapy - Medicare	\$ 67,249	67,249			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (23,865)	(23,865)			
c. Speech Therapy - Non-Medicare	\$ 63,073	63,073			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (27,320)	(27,320)			
5. a. Occupational Therapy - Medicare	\$ 1,100,746	1,100,746			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (390,631)	(390,631)			
c. Occupational Therapy - Non-Medicare	\$ 569,704	569,704			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (247,608)	(247,608)			
6. a. Other (<i>Specify</i>) - Medicare	\$ 29,062	29,062			
b. Other (<i>Specify</i>) - Non-Medicare	\$ 15,352	15,352			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 10,913,612	10,913,612			
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>)	\$ 597	597			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ 600	600			
V. Total Other Revenue (1 thru 8)	\$ 1,197	1,197			
VI. Total All Revenue (III +V)	\$ 10,914,809	10,914,809			

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-a	Medicare Part A	X-Ray	14,667.52	-	0
II-6-a	Medicare Part A	Radiology Service	-	-	0
II-6-a	Medicare Part A	Outpatient Therapy Program	-	-	0
II-6-a	Medicare Part A	Laboratory	25,659.59	-	0
II-6-a	Medicare Part A	Respiratory Therapy & Supplie	164.00	-	0
II-6-a	Medicare Part A	Nursing Treatment Supplies	-	-	0
II-6-a	Medicare Part A	Audiology	45.17	-	0
II-6-a	Medicare Part A	Incontinency	-	-	0
II-6-a	Medicare Part A	Oxygen & Supplies	-	-	0
II-6-a	Medicare Part A	Physician Visit	-	-	0
II-6-a	Medicare Part A	Ambulance	-	-	0
II-6-a	Medicare Part A	Flu Shot	4,512.00	-	0
II-6-a	Contractuals-Medicare	X-Ray	(5,205.18)	-	0
II-6-a	Contractuals-Medicare	Radiology Service	-	-	0
II-6-a	Contractuals-Medicare	Outpatient Therapy Program	-	-	0
II-6-a	Contractuals-Medicare	Laboratory	(9,106.03)	-	0
II-6-a	Contractuals-Medicare	Respiratory Therapy & Supplie	(58.20)	-	0
II-6-a	Contractuals-Medicare	Nursing Treatment Supplies	-	-	0
II-6-a	Contractuals-Medicare	Audiology	(16.03)	-	0
II-6-a	Contractuals-Medicare	Incontinency	-	-	0
II-6-a	Contractuals-Medicare	Oxygen & Supplies	-	-	0
II-6-a	Contractuals-Medicare	Physician Visit	-	-	0
II-6-a	Contractuals-Medicare	Ambulance	-	-	0
II-6-a	Contractuals-Medicare	Flu Shot	(1,601.21)	-	0
Total Other Resident Revenue - Medicare			\$ 29,062	\$ -	\$ -
			\$ (0)		

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-b	Medicaid	X-Ray	234.00	-	-
II-6-b	Medicaid	Radiology Service	-	-	-
II-6-b	Medicaid	Outpatient Therapy Program	-	-	-
II-6-b	Medicaid	Laboratory	129.83	-	-
II-6-b	Medicaid	Respiratory Therapy & Supplie	123.00	-	-
II-6-b	Medicaid	Nursing Treatment Supplies	-	-	-
II-6-b	Medicaid	Audiology	-	-	-
II-6-b	Medicaid	Incontinency	-	-	-
II-6-b	Medicaid	Oxygen & Supplies	-	-	-
II-6-b	Medicaid	Physician Visit	-	-	-
II-6-b	Medicaid	Ambulance	-	-	-
II-6-b	Medicaid	Flu Shot	-	-	-
II-6-b	Contractuals Medicaid	X-Ray	(122.88)	-	-
II-6-b	Contractuals Medicaid	Radiology Service	-	-	-
II-6-b	Contractuals Medicaid	Outpatient Therapy Program	-	-	-
II-6-b	Contractuals Medicaid	Laboratory	(68.18)	-	-
II-6-b	Contractuals Medicaid	Respiratory Therapy & Supplie	(64.59)	-	-
II-6-b	Contractuals Medicaid	Nursing Treatment Supplies	-	-	-
II-6-b	Contractuals Medicaid	Audiology	-	-	-
II-6-b	Contractuals Medicaid	Incontinency	-	-	-

II-6-b	Contractuals Medicaid	Oxygen & Supplies	-	-	-
II-6-b	Contractuals Medicaid	Physician Visit	-	-	-
II-6-b	Contractuals Medicaid	Ambulance	-	-	-
II-6-b	Contractuals Medicaid	Flu Shot	-	-	-
II-6-b	Private and Other	X-Ray	7,872.79	-	-
II-6-b	Private and Other	Radiology Service	-	-	-
II-6-b	Private and Other	Outpatient Therapy Program	-	-	-
II-6-b	Private and Other	Laboratory	18,384.21	-	-
II-6-b	Private and Other	Respiratory Therapy & Supplie	410.00	-	-
II-6-b	Private and Other	Nursing Treatment Supplies	-	-	-
II-6-b	Private and Other	Audiology	-	-	-
II-6-b	Private and Other	Incontinency	-	-	-
II-6-b	Private and Other	Oxygen & Supplies	-	-	-
II-6-b	Private and Other	Physician Visit	-	-	-
II-6-b	Private and Other	Ambulance	-	-	-
II-6-b	Private and Other	Flu Shot	-	-	-
II-6-b	Private and Other	Capitation Contracts	-	-	-
II-6-b	Contractuals-Non-Medicaid	X-Ray	(3,408.81)	-	-
II-6-b	Contractuals-Non-Medicaid	Radiology Service	-	-	-
II-6-b	Contractuals-Non-Medicaid	Outpatient Therapy Program	-	-	-
II-6-b	Contractuals-Non-Medicaid	Laboratory	(7,960.11)	-	-
II-6-b	Contractuals-Non-Medicaid	Respiratory Therapy & Supplie	(177.52)	-	-
II-6-b	Contractuals-Non-Medicaid	Nursing Treatment Supplies	-	-	-
II-6-b	Contractuals-Non-Medicaid	Audiology	-	-	-
II-6-b	Contractuals-Non-Medicaid	Incontinency	-	-	-
II-6-b	Contractuals-Non-Medicaid	Oxygen & Supplies	-	-	-
II-6-b	Contractuals-Non-Medicaid	Physician Visit	-	-	-
II-6-b	Contractuals-Non-Medicaid	Ambulance	-	-	-
II-6-b	Contractuals-Non-Medicaid	Flu Shot	-	-	-
			-	-	-
Total Other Resident Revenue			\$ 15,352	\$ -	\$ -
			\$ (0)		

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Pg 30 line 1	430055	Interest On Overdue Accounts	597.16	0	0
0	0	0	-	0	0
0	0	0	-	0	0
Total Interest Income			\$ 597	\$ -	\$ -
			\$ 0		

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)	
Pg 30 line 1	0 430060	-	-	-	
Pg 30 line 1	Class Action Settlement	599.99	-	-	
Pg 30 line 1	RESIDENT COUNCIL FUN	-	-	-	
Pg 30 line 1	0	-	-	-	
Pg 30 line 1	0	-	-	-	
Pg 30 line 1	0	-	-	-	
Total Other Revenue			\$ 600	\$ -	\$ -
			\$ (0)		

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Center	2202-C	9/30/2018	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	2,697
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,048,099
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	4,968
4 Inventories			\$	27,279
5. Prepaid Expenses			\$	49,710
a. Prepaid Expenses	22,475			
b. Prepaid Property Tax	21,659			
c. Prepaid Personal Property Tax				
d. Prepaid Personal Property Tax	5,576			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

A-9. Total Current Assets (Lines A1 thru 8)			\$	1,132,752
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	58,519	\$	38,644
	Accum. Depreciation	19,875		
	Net			
3. Buildings	*Historical Cost	212,143	\$	148,194
	Accum. Depreciation	63,949		
	Net			
4. Leasehold Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		
	Net			
5. Non-Movable Equipment	*Historical Cost	303,989	\$	170,729
	Accum. Depreciation	133,260		
	Net			
6. Movable Equipment	*Historical Cost	262,564	\$	105,296
	Accum. Depreciation	157,268		
	Net			
7. Motor Vehicles	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		
	Net			
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

B-10. Total Fixed Assets (Lines B1 thru 9)			\$	462,863

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2018	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$ 1,595,615	
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>)			\$	
I/C Due to/Due From Owned			(4,875,785)	
I/C Due to/Due From Multicare				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ (4,875,785)	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ (3,280,169)	

* 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 Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2018	Page 33	of 37
Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				\$ 451,469
2. Notes Payable (<i>itemize</i>)				\$

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>)				\$ 203,253
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$
6. Accrued Payroll Taxes Payable				\$ 1,093
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>)				\$ 258,263
Accrued Provider/Bed Tax		110,965	Accr Gross Rec Tax-FY1	18,989
A/R Credit Gross Up Liability		95,366	Deferred Revenue	23,212
Accr Exp Fuel Oil, Water and Sewer		9,731	Accr Exp Suspense	
Accr Exp Other			Accr Sales and Use Tax -	
A-13. Total Current Liabilities (Lines A1 thru 12)				\$ 914,078

* 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 9/30/2018	Page 34	of 37
Account				Amount	
Total Brought Forward:				914,078	
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>)				\$	
LT Debt-Financing Obligation		262,972	262,972		
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 262,972	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 1,177,050	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Willows Care and Rehabilitation Cent	2202-C	9/30/2018	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(3,877,470)
6. Gain or Loss for Period			\$	(579,749)
	10/1/2017	thru	9/30/2018	
7. Total Net Worth			\$	(4,457,219)
C. Total Reserves and Net Worth			\$	(4,457,219)
D. Total Liabilities, Reserves, and Net Worth			\$	(3,280,169)

H. Changes in Total Net Worth

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2018	Page 36	of 37	
Account			Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2017			\$	(3,877,472)	
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	10,914,809	
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	11,494,556	
D. Net Income or Deficit			\$	(579,747)	
E. Balance			\$	(4,457,219)	
F. Additions					
1. Additional Capital Contributed (<i>itemize</i>)					
2. Other (<i>itemize</i>)					
F-3. Total Additions			\$		
G. Deductions					
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$		
Name and Address (<i>No., City, State, Zip</i>)		Title	Amount		
2. Other Withdrawings (<i>Specify</i>)			\$		
Purpose		Amount			
3. Total Deductions			\$		
H. <i>Balance at End of Period</i>			\$	(4,457,219)	

I. Preparer's/Reviewer's Certification

Name of Facility Willows Care and Rehabilitation Center	License No. 2202-C	Report for Year Ended 9/30/2018	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Thomas Farnan Title -Sr. Director of Reimbursement				
Address Address			Phone Number	
200 Brickstone Square, Andover, MA 01810			978-247-5029	