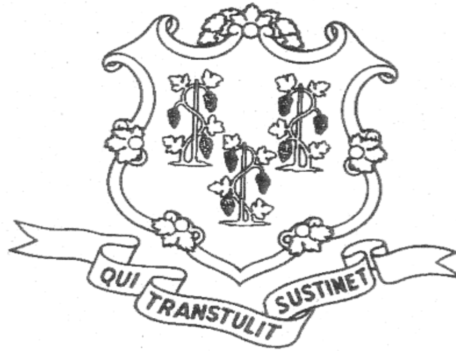
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2019

Name of Facility (as licensed)		
WORCESTER SKILLED CARE CENTER, INC		
Address (No. & Street, City, State, Zip Code)		
59 ACTON STREET ,WORCESTER MA. 01604		
Type of Facility		
☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☑ CT/NY Neuro
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019	

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	26450		

For Department Use Only

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

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

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2019	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for WORCESTER SKILLED CARE CENTER, INC [facility name], for the cost report period beginning October 1, 2018 and ending September 30, 2019, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) SUSAN JENNEY			Printed Name (Owner)	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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State of Connecticut
Department of Social Services
55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility WORCESTER SKILLED CARE CENTER, INC	Period Covered:		From 10/1/2018	To 9/30/2019
Address of Facility 59 ACTON STREET ,WORCESTER MA. 01604				
Report Prepared By CLIFTONLARSONALLLEN LLP	Phone Number 617-984-8100		Date 1/29/2020	

Item		Total	CCNH	RHNS	CT/NY Neuro
1. Dietary wages paid	$				
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$				
5. All other wages paid	$				
6. ***Total Wages Paid***	$				
7. Total salaries paid	$				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
508-791-3147	9/30/2019	2	37

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

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

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
SUSAN JENNEY	NH5353 (Massachusetts)

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2019	3 / 37

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

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page of
WORCESTER SKILLED CARE CENTER,	0723MA	9/30/2019	3A 37

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

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
SENIOR RESIDENTIAL CARE WORCESTER, INC	63KENDRICK ST., NEEDHAM, MA 02494	MA

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

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2019	3B	37

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

Owner(s) of Facility

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2019	4	37

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
WINGATE HEALTHCARE, INC	63 KENDRICK ST., NEEDHAM, MA 02494	⊙	○	10%	MANAGEMENT SERVICES	Page 16, m12	399,524	399,524
WINGATE HEALTHCARE INC	63 KENDRICK ST., NEEDHAM, MA 02494	○	⊙		CENTRAL OFFICE EXPENSE	Page 16, m13	46,975	46,975
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, IN(	0723MA	9/30/2019	5	37

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

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

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

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

Because of significant differences in cost of care between neurobehavioral residents and non-neurobehavioral residents costs are allocated between non-neurobehavioral residents ("CCH" heading in 1st column throughout this cost report) and neurobehavioral residents, which are further allocated between Massachusetts neurobehavioral residents ("MA Neuro" heading in 2nd column throughout this cost report) and Connecticut & New York neurobehavioral residents ("CT/NY Neuro" heading in 3rd column throughout this cost report). Nursing costs are allocated by applying facility staffing FTEs

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

Management services are 5% of revenue. Central office expense is allocated based on number of beds.

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

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

N/A

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2019	6	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					
CSI LEASING, INC 9900 OLD OLIVE ST. RD, STE 101, ST LOUIS, MO 63141	○	⊙	EQUIPMENT	FY14	>1 YEAR	4,316	4,316
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total ***** 4,316

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

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE C	0723MA	9/30/2019	7	37

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

⦿ Accrual　○ Cash　○ Modified Cash

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

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

1	AUDIT, TAX & COST REPORTING SERVICES	$ 24,820
2		$
3		$
4		$
	Charge for Services Provided	$ 24,820

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

⦿ Yes　○ No　Page 15, Line 1.d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Jeffrey P. Campbell	508-864-3357
2 West Central Fam & Coun	413-592-1980
3 MA Secretary of State	
4 Patrice Martin	617-816-8258
5	

Address (*No. & Street, City, State, Zip Code*)
1 1020 Stafford St., Rochdale, MA 01542
2 103 Myron St., Ste A, W Springfield, MA 01089
3 Boston, MA
4 66 Forest St., Baldwinville, MA 01436
5

Services Provided by This Firm (*describe fully*)

1	Rogers Guardianship Review	$ 1,750
2	Rogers Guardianship Review	$ 2,000
3	Annual Report Fees	$ 218
4	Rogers Guardianship Review	$ 300
5		$
	Charge for Services Provided	$ 4,268

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

⦿ Yes　○ No　Page 15,Line 1e

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2019	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total CT/NY Neuro	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	CT/NY Neuro	Total	CCNH	RHNS	CT/NY Neuro
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	173	173			173	173			173	173		
B. On last day of THIS report period	173	173			173	173			173	173		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	150	109	4	37	150	109	4	37	141	103	3	35
B. As of midnight of THIS report period	143	104	3	36	141	103	3	35	143	104	3	36
3. Total Number of Days Care Provided During Period												
A. Medicare	1,490	1,490			1,029	1,029			461	461		
B. Medicaid (Conn.)	2,683			2,683	1,924			1,924	759			759
C. Medicaid (other states)	45,207	37,637	1,119	6,451	33,976	28,246	843	4,887	11,231	9,391	276	1,564
D. Private Pay	732	732			625	625			107	107		
E. State SSI for RCH												
F. Other (Specify) Managed Care	1,834	1,834			1,309	1,309			525	525		
G. Total Care Days During Period (3A thru F)	51,946	41,693	1,119	9,134	38,863	31,209	843	6,811	13,083	10,484	276	2,323
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	51,946	41,693	1,119	9,134	38,863	31,209	843	6,811	13,083	10,484	276	2,323

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, I	0723MA	9/30/2019	9	37

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

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

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

Change in Resident Days	CCNH	RHNS	CT/NY Neuro
1st change			
2nd change			
3rd change			
4th change			

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

	Medicare	Medicaid		Self-Pay			Other State Assisted	
Item	CCNH	CCNH	RHNS	CCNH	RHNS	CT/NY Neuro	R.C.H.	ICF-MR
No. of Residents	2		133	8				
Per Diem Rate								
a. One bed rm.				380.00	975.00	Vent		
b. Two bed rms.				355.00	853.00	Vent		
c. Three or more bed rms.				342.00	853.00	Vent		

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

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2019	10	37

Are time records maintained by all individuals receiving compensation? ☉ Yes ○ No

Item	Total Cost and Hours					
	CCNH	Hours	RHNS	Hours	CT/NY Neuro	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	92,558	1,663	2,484	45	20,277	364
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	214,733	9,931	5,763	267	47,043	2,176
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	41,385	1,348	1,111	36	9,066	295
b. Other Maintenance Workers	39,742	1,907	1,067	51	8,707	418
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	52,393	1,669	1,406	45	11,478	366
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	171,561	3,254	4,605	87	37,585	713
b. RN						
1. Direct Care	724,444	19,478	88,948	2,392	726,052	19,521
2. Administrative**	175,120	4,590	4,700	123	38,365	1,006
c. LPN						
1. Direct Care	793,054	26,833	97,372	3,295	794,813	26,892
2. Administrative**						
d. Aides and Attendants	869,193	50,666	106,721	6,221	871,122	50,778
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	66,281	5,054	1,779	136	14,521	1,107
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	26,389	283	708	8	5,781	
n. Marketing	70,648	2,548	1,896	68	15,477	
o. Other (Specify) See Attached Schedule			125,971	6,237	1,028,259	50,911
A-13. Total Salary Expenditures	3,337,501	129,225	444,531	19,009	3,628,547	154,548

* 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)

Position	CCNH		RHNS		CT/NY Neuro	
	$	Hours	$	Hours	$	Hours
Salaries- Director of Neurobehavioral	$ -	-	$ 7,138	223	$ 58,267	1,817
Salaires-Behavioral Spec	$ -	-	$ 61,450	4,309	$ 501,595	35,176
Salaries-Respiratory Therapy	$ -	-	$ 50,098	1,627	$ 408,929	13,281
Salaries - Social Service Neurobehavioral	$ -	-	$ 7,285	78	$ 59,468	637
Total	$ -	-	$ 125,971	6,237	$ 1,028,259	50,911

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		CT/NY Neuro	
	$	Hours	$	Hours	$	Hours
X-Ray	$ 94	-	$ -	-	$ 281	-
Lab	$ 1,952	-	$ -	-	$ 5,857	-
Psychiatric	$ -	-	$ -	-	$ 789	-
Total	$ 2,046	-	$ -	-	$ 6,927	-

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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
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2019	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	CT/NY Neuro							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2019	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	CT/NY Neuro							
Section III - Administrators* **										
SUSAN JENNEY	92,558	2,484	20,277		Administrator	2,072	A.2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2019	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	CT/NY Neuro	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist	16,678		448		3,654	
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	41,393				124,180	
b. Other						
6. Social Worker	23,578		633		5,165	
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	101,130		2,714		22,155	
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	26,375				79,126	
b. Other						
10. Occupational Therapist						
a. Resident Care	44,442				133,325	
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	19,023		2,336		19,065	
2. Administrative***						
b. LPN						
1. Direct Care	46,899		5,758		47,003	
2. Administrative***						
c. Aides	294,643		7,908		64,550	
d. Other						
12. Other (Specify)						
See Attached Schedule	2,046				6,927	
B-13 Total Fees Paid in Lieu of Salaries	616,207		19,797		505,149	

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2019	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
OMNICARE, INC.	Pharmacy Consulting	○	⊙	
West Central Fam & Counseling	Psychiatric Services	○	⊙	
Rehab Care Group, Inc.	PT Therapist	○	⊙	
William H. Johnson	Social Worker	○	⊙	
Bond Medical Consultants	Medical Director Physician	○	⊙	
Daniel Tanenbaum, MD	Physician	○	⊙	
UMASS Memorial Healthcare	Medical Director Physician	○	⊙	
Rehab Care Group, Inc.	Speech Therapist	○	⊙	
Rehab Care Group, Inc.	Occupational Therapist	○	⊙	
Expert Staffing	Nursing	○	⊙	
Worldwide Staffing	Nursing	○	⊙	
Favorite Healthcare Staffing	Nursing	○	⊙	
IntelyCare Inc	Nursing	○	⊙	
MSG Staffing, Inc	Nursing	○	⊙	
Expert Staffing	Nursing	○	⊙	
IntelyCare Inc	Nursing	○	⊙	
MSG Staffing, Inc	Nursing	○	⊙	
Expert Staffing	C.N.A. Nursing	○	⊙	
Worldwide Staffing	C.N.A. Nursing	○	⊙	
Favorite Healthcare Staffing	C.N.A. Nursing	○	⊙	
		○	⊙	
		○	⊙	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2019	15	37

Item		Total	CCNH	RHNS	CT/NY Neuro
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	157,735	71,039	9,462	77,234
2. Disability Insurance	$				
3. Unemployment Insurance	$				
4. Social Security (F.I.C.A.)	$	645,092	290,530	38,696	315,866
5. Health Insurance	$	508,834	229,163	30,523	249,148
6. Life Insurance (employees only) (not-owners and not-operators)	$	14,082	6,342	845	6,895
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	22,094	9,950	1,325	10,818
8. Uniform Allowance	$				
9. Other (*Specify*) See Attached Schedule	$	8,725	3,929	523	4,272
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans forOwners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	24,820	19,921	535	4,364
e. Legal (*Services should be fully described on Page 7)*	$	4,268	3,426	92	750
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	37,343	29,972	804	6,566
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	18,659	14,976	402	3,281
2. Cellular Phones	$	774	621	17	136
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*) See Attached Schedule	$				
3. Resident Day User Fee	$	1,095,409	879,199	23,597	192,613
Subtotal	$	2,537,835	1,559,070	106,821	871,944

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	CT/NY Neuro
Employee Benefits Other	$ 3,929	$ 523	$ 4,272
Total	$ 3,929	$ 523	$ 4,272

Schedule of Other Taxes

Description	CCNH	RHNS	CT/NY Neuro
Total	$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2019	16	37

Item		Total	CCNH	RHNS	CT/NY Neuro
Subtotals Brought Forward:		2,537,835	1,559,070	106,821	871,944
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	3,256	2,613	70	573
3. Gifts to Staff and Residents	$	537	431	12	94
4. Employee Travel	$	2,749	2,206	59	483
5. Education Expenses Related to Seminars and Conventions	$	5,822	4,673	125	1,024
6. Automobile Expense (*not purchase or depreciation*)	$	2,949	2,367	64	519
7. Other (*Specify*) See Attached Schedule	$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	4,293	3,446	92	755
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$	11,473	9,208	247	2,017
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	6,408	5,143	138	1,127
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	13,670	10,972	294	2,404
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions*** See Attached Schedule	$	159	128	3	28
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$	399,524	320,667	8,606	70,251
13. Other (*Specify*) See Attached Schedule	$	353,391	283,639	7,613	62,139
C-14 Total Administrative & General Expenditures	$	3,342,066	2,204,564	124,145	1,013,357

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

Schedule of Other Advertising

Description	CCNH	RHNS	CT/NY Neuro
Advertising-Promotional	$ 1,113	$ 30	$ 244
Marketing	$ 8,095	$ 217	$ 1,773
0	$ -	$ -	$ -
Total Other Advertising	$ 9,208	$ 247	$ 2,017

Schedule of Dues

Description	CCNH	RHNS	CT/NY Neuro
JCAHO	$ 2,420	$ 65	$ 530
License & Dues -Patient Relatied	$ 6,586	$ 177	$ 1,443
License & Dues- Non Patient related	$ 1,966	$ 53	$ 431
Total Dues	$ 10,972	$ 294	$ 2,404

Schedule of Contributions

Description	CCNH	RHNS	CT/NY Neuro
Donations	$ 128	$ 3	$ 28
Total Contributions	$ 128	$ 3	$ 28

Schedule of Other Administrative and General

Description	CCNH	RHNS	CT/NY Neuro
Physician Care	$ 31,470	$ 845	$ 6,894
Payroll Processing Fees	$ 15,853	$ 425	$ 3,473
Computer Expense	$ 69,400	$ 1,863	$ 15,204
Bookkeeping Service	$ 11,194	$ 300	$ 2,452
Professional Service	$ 26,816	$ 720	$ 5,875
Central Office Expense	$ 37,703	$ 1,012	$ 8,260
Bank Fees	$ 12,132	$ 326	$ 2,658
Late Charges & Fines & Penalties	$ 77,728	$ 2,086	$ 17,028
Miscellaneous Expenses	$ 1,343	$ 36	$ 294
Total Other Administrative and General	$ 283,639	$ 7,613	$ 62,139

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
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Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
WINGATE HEALTHCARE INC, 63 KENDRICK ST., NEEDHAM, MA 02494	399,524	HOME OFFICE SERVICES INCLUDING ACCOUNTING, FINANCE, NURSING, ADMINISTRATION, OPERATIONS MANAGEMENT,	pg. 16, m12
WINGATE HEALTHCARE INC, 63 KENDRICK ST., NEEDHAM, MA 02494	46,975	Central Office Services	pg 16, m13

*** 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
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2019	18 | 37

Item		Total	CCNH	RHNS	CT/NY Neuro
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$				
2. Non-Food Supplies	$	643	516	14	113
3. Other (*Specify*)____________________ Dietary Supplements	$	25,758	20,674	555	4,529
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	904,598	726,050	19,486	159,061
c. Other (*Specify*)________________________	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	930,999	747,240	20,055	163,704

2E. Dietary Questionnaire	Total	CCNH	RHNS	CT/NY Neuro
F. Resident Meals: Total no. of meals served per day:*				

	Question	Yes	No	
G.	Is cost of employee meals included in 2D?	○ Yes	⦿ No	
H.	Did you receive revenue from employees?	○ Yes	⦿ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	○ Yes	⦿ No	If yes, specify cost.
K.	Is any revenue collected from these people?	○ Yes	⦿ 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?	○ Yes	⦿ No	If yes, specify cost.
N.	Is any revenue collected from employees?	○ Yes	⦿ No	If yes, specify amt.
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

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

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

Name of Facility	License No.	Report for Year Ended	Page of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2019	19 | 37

Item		Total	CCNH	RHNS	CT/NY Neuro
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	Amt. $	808	649	17	142
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	232,959	46,745	20,323	165,891
c. Other (*Specify*)	$				
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	233,767	47,393	20,341	166,033

3E. Laundry Questionnaire

	Question	Yes	No	
F.	Is cost of employee laundry included in 3D?	○ Yes	⦿ No	If yes, specify cost.
G.	Did you receive revenue from employees?	○ Yes	⦿ 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?	○ Yes	⦿ No	If yes, specify cost.
J.	Did you receive revenue from these people?	○ Yes	⦿ No	If yes, specify amt.
K.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3D.

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, IN	0723MA	9/30/2019	20	37

Item			Total	CCNH	RHNS	CT/NY Neuro
4. Housekeeping						
a. In-House Care	Sq. Ft. Serviced by Personnel					
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	27,030	21,695	582	4,753
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	232,959	186,978	5,018	40,963
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	259,989	208,673	5,601	45,716
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$				
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	439,234	352,539	9,462	77,233
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$				
f. X-rays and Related Radiological Procedures***		$				
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$				
i. Recreation		$	10,023	8,045	216	1,762
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	489,171	68,876		420,295
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	938,428	429,460	9,678	499,290

* 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	CT/NY Neuro
Ambulance	$ 740	$ -	$ 14,053
X-ray	$ 353	$ -	$ 6,705
Pharmacy	$ 55,522	$ -	$ 166,565
Complex Medical Equipment	$ 8,899	$ -	$ 169,088
Oxygen	$ 909	$ -	$ 17,265
Laboratory	$ 1,396	$ -	$ 26,515
IV	$ 1,058	$ -	$ 20,104
Total Other Resident Care	$ 68,876	$ -	$ 420,295

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

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2019	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers: Yes	Related ** to Owners, Operators, Officers: No	Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***: CCNH	RHNS	CT/NY Neuro	Pg	Line
HEALTHCARE SERVICES GROUP. INC	STE 300 BENSALEM, PA 19020	○	⊙		HOUSEKEEPING SERVICES	186,978	5,018	40,963	20	4b
HEALTHCARE SERVICES GROUP. INC	STE 300 BENSALEM, PA 19020	○	⊙		LAUNDRY SERVICES	46,745	20,323	165,891	19	3b
BULK TV & INTERNET	#100, RALEIGH, NC 27615	○	⊙		CABLE SERVICES	13,035	350	2,856	22	6a
AJ LETOURNEAU, INC	CUTOFF, WORCESTER, MA	○	⊙		WASTE MANAGEMENT	18,922	508	4,145	22	6a
HEALTHCARE SERVICES GROUP. INC	STE 300 BENSALEM, PA 19020	○	⊙		DIETARY SERVICES	726,050	19,486	159,061	18	2b
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* List all contracted services over $10,000. Use additional sheets if necessary.
** Refer to Page 4 for definition of related.
*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended	Page of
WORCESTER SKILLED CARE CENTER, I	0723MA	9/30/2019	22 | 37

Item		Total	CCNH	RHNS	CT/NY Neuro
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	219,141	87,943	14,319	116,879
b. Heat	$	53,701	43,102	1,157	9,443
c. Light & Power	$	183,648	147,400	3,956	32,292
d. Water	$	96,860	77,742	2,087	17,032
e. Equipment Lease (*Provide detail on page 6*)	$	4,316	3,464	93	759
f. Other (*itemize*)	$	33,156	26,612	714	5,830
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	590,822	386,263	22,325	182,234
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	84,214	67,592	1,814	14,808
c. Non-Movable Equipment	$				
d. Movable Equipment	$	61,925	49,702	1,334	10,889
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	146,139	117,294	3,148	25,697
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$				
9. Rental payments on leased real property less real estate taxes included in item 10b	$	499,243	400,703	10,754	87,785
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	207,436	166,493	4,469	36,475
c. Personal property taxes	$	20,196	16,210	435	3,551
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	873,014	700,700	18,806	153,508

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	CT/NY Neuro
Rent Other	$ 12,039	$ 323	$ 2,638
Equipment Rental	$ 14,572	$ 391	$ 3,192
Total Other Repairs and Maintenance	$ 26,612	$ 714	$ 5,830

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2019	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period	841,620		841,620	471,479	SL	Var	84,162	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	1,035		1,035				52	
B-4. Subtotal								84,214
C. **Non-Movable Equipment**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquisition		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. VAN	X		7	2007	51,226		51,226	51,226	SL			
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					974,328		974,328	677,707			60,428	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					29,933						1,497	
D-3. Subtotal												61,925
E. ***Total Depreciation***												146,139

Schedule of Land Improvements Acquired during this report period

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

***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:					
3/26/2019	Replaced Floor of Elevator	$ 1,035	10	$ 52	
Total additions for Building Improvement		$ 1,035		$ 52	*
Deletions:					
Total deletions for Building Improvement		$ -		$ -	**

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

Schedule of Non-Movable Equipment Acquired during this report peri

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

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

Schedule of Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
SEE ATTACHED	SEE ATTACHED	$ 29,933	10	$ 1,497	
Total additions for Movable Equipmen		$ 29,933		$ 1,497	*
Deletions:					
Total deletions for Movable Equipmen		$ -		$ -	**

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report peri

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

***Ties to Page 24, Line C3**
****Ties to Page 24, Line C2**

7. Movable Equipment:

Additions

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
10/4/18	IBSE0001 10/2/18 INSTALL3KEYPA	2,108	10.00	105
3/11/18	WJSM0001 2/27/18 NEW PUMPS	5,731	10.00	287
1/25/18	WJSM0001 1/23/18 PUMP REPLACED	3,490	10.00	175
12/11/17	WJSM0001 12/8/17 NEW PUMP	3,543	10.00	177
10/26/18	WJSM0001 10/22/18 MOTOR/FAN	2,250	10.00	113
8/15/18	EAGL0005 8/15/18 ROLLERS/CLUTC	5,659	10.00	283
1/31/19	IBSE0001 ELEV ANTENNA	1,772	10.00	89
10/15/18	HARB0002 10/15/18 BLENDER	4,218	10.00	211
3/31/19	HILL001 LIFT	1,160	10.00	58

Total		29,933		1,497

Deletions

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2019	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.

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

Name of Facility	License No.	Report for Year Ended	Page of
WORCESTER SKILLED CARE CEN	0723MA	9/30/2019	25 | 37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	173
6. Square Footage	
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of ___________				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
Care Capital Prop. 353 N. Clark Ste 2000. Chicago, IL 60654	Land & Building	01/31/06	1/31/06-2/1/20	499,243

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

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

Name of Facility	License No.	Report for Year Ended	Page of
WORCESTER SKILLED CARE CE[	0723MA	9/30/2019	26 | 37

Item			Total	CCNH	RHNS	CT/NY Neuro
12. Interest A. Building, Land Improvement & Non-Movable Equipment 1. First Mortgage		$				
Name of Lender	Rate					
Address of Lender						
2. Second Mortgage		$				
Name of Lender	Rate					
Address of Lender						
3. Third Mortgage		$				
Name of Lender	Rate					
Address of Lender						
4. Fourth Mortgage		$				
Name of Lender	Rate					
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount		$				
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5)		$				

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
WORCESTER SKILLED CARE C	0723MA	9/30/2019	27 | 37

Item		Total	CCNH	RHNS	CT/NY Neuro
Subtotals Brought Forward:					
12. C. Movable Equipment 1. Automotive Equipment	$				
A. Item | Rate | Amount					
Lender					
Address of Lender					
2. Other (*Specify*)	$				
A. Item | Rate | Amount					
Lender					
Address of Lender					
B. Item | Rate | Amount					
Lender					
Address of Lender					
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)	$				
12. D. Other Interest Expense (*Specify*) Interest on working capital	$	17,307	13,891	373	3,043
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)	$	17,307	13,891	373	3,043
14. Insurance a. Insurance on Property (buildings only)	$	12,281	9,857	265	2,159
b. Insurance on Automobiles	$				
c. Insurance other than Property (as specified above) 1. Umbrella (*Blanket Coverage*)	$	221,886	178,091	4,780	39,016
2. Fire and Extended Coverage	$				
3. Other (*Specify*)	$				
14d. ***Total Insurance Expenditures (14a + b + c)***	$	234,167	187,948	5,044	41,175
15. ***Total All Expenditures (A-13 thru C-14)***	$	15,972,290	8,879,839	690,696	6,401,755

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2019	28 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	CT/NY Neuro
Page 10 - Salaries and Wages								
1.			Outpatient Service Costs	$				
2.	10	12.n.	Salaries not related to Resident Care	$	88,021	70,648	1,896	15,477
3.			Occupational Therapy	$				
4.			Other - See attached Schedule	$				
Page 13 - Professional Fees								
5.			Resident Care Physicians **	$				
6.			Occupational Therapy	$				
7.			Other - See attached Schedule	$				
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.			Bad Debts	$				
10.			Accounting	$				
10a.			Legal	$				
11.			Telephone	$				
12.	15	1.h.2	Cellular Telephone	$	774	621	17	136
13.			Life insurance premiums on the life of Owners, Partners, Operators	$				
14.	16	3	Gifts, flowers and coffee shops	$				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	$				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	$				
17.			Automobile Expense (e.g. personal use)	$				
18.	16	m3	Unallowable Advertising *	$	11,473	9,208	247	2,017
19.			Income Tax / Corporate Business Tax	$				
20.			Fund Raising / Contributions	$	160	128	3	28
21.			Unallowable Management Fees	$				
22.	30	IV7	Barber and Beauty	$				
23.			Other - See attached Schedule	$	116,712	88,129	3,120	25,464
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)	$	217,140	168,734	5,283	43,123

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	CT/NY Neuro
15	1a	MARKETING BENEFITS	$ 7,092	$ 945	$ 7,710
16	M13	Late Charges & Fines & Penalties	$ 77,728	$ 2,086	$ 17,028
16	M13	Miscellaneous Expenses	$ 1,343	$ 36	$ 294
16	M8	License & Dues- Non Patient related	1966.423786	52.77692219	430.7992916
Total Other A&G Adjustments			$ 88,129	$ 3,120	$ 25,464

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

Name of Facility	License No.	Report for Year Ended	Page of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2019	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	CT/NY Neuro
			Subtotals Brought Forward	$	217,140	168,734	5,283	43,123
Page 20 - Resident Care Supplies*								
27.			Prescription Drugs	$				
28.			Ambulance/Limousine	$				
29.			X-rays, etc	$				
30.			Laboratory	$				
31.			Medical Supplies	$				
32.			Oxygen (non emergency)	$				
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	489,171	68,876		420,295
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	$				
43.			Interest Income on Account Rec.	$				
44.			Other - Miscellaneous Administrative	$	1,984	1,592	43	349
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)***	$	708,295	239,203	5,326	463,766

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

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	CT/NY Neuro
		Ambulance	$ 740	$ -	$ 14,053
		X-ray	$ 353	$ -	$ 6,705
		Pharmacy	$ 55,522	$ -	$ 166,565
		Complex Medical Equipment	$ 8,899	$ -	$ 169,088
		Oxygen	$ 909	$ -	$ 17,265
		Laboratory	$ 1,396	$ -	$ 26,515
		IV	$ 1,058	$ -	$ 20,104
Total Other Ancillary Costs			$ 68,876	$ -	$ 420,295

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	CT/NY Neuro

Total Other Adjustments			$ -	$ -	$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	CT/NY Neuro
30	IV, 8	Other Income	$ 1,592	$ 43	$ 349
Total Other Adjustments			$ 1,592	$ 43	$ 349

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
WORCESTER SKILLED CARE CENTE	0723MA	9/30/2019	30 | 37

Item		Total	CCNH	RHNS	CT/NY Neuro
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	1,078,182			1,078,182
b. Medicaid Room and Board Contractual Allowance **	$				
2. a. Medicaid (*All other states*)	$	12,029,561	9,655,190	259,136	2,115,235
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	993,507	993,507		
b. Medicare Room and Board Contractual Allowance **	$				
4. a. Private-Pay Residents and Other	$	1,073,693	1,073,693		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	108,084	108,084		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(108,084)	(108,084)		
c. Prescription Drugs - Non-Medicare	$	29,200	7,300		21,900
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(22,255)	(5,564)		(16,691)
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	323,771	323,771		
b. Physical Therapy - Medicare Contractual Allowance **	$	(232,306)	(232,306)		
c. Physical Therapy - Non-Medicare	$	91,835	22,959		68,876
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(67,579)	(16,895)		(50,684)
4. a. Speech Therapy - Medicare	$	188,955	188,955		
b. Speech Therapy - Medicare Contractual Allowance **	$	(119,189)	(119,189)		
c. Speech Therapy - Non-Medicare	$	70,917	17,729		53,188
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(70,917)	(17,729)		(53,188)
5. a. Occupational Therapy - Medicare	$	474,271	474,271		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(316,474)	(316,474)		
c. Occupational Therapy - Non-Medicare	$	68,157	17,039		51,118
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(76,159)	(19,040)		(57,119)
6. a. Other *(Specify)* - Medicare	$	6,258	6,258		
b. Other *(Specify)* - Non-Medicare	$	7,225	361		6,864
III. *Total Resident Revenue* (Section I. thru Section II.)	$	15,530,652	12,053,836	259,136	3,217,680
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	46	37	1	8
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	1,688,576	1,355,288	36,375	296,913
V. Total Other Revenue (1 thru 8)	$	1,688,622	1,355,325	36,376	296,921
VI. Total All Revenue (III +V)	$	17,219,274	13,409,161	295,512	3,514,602

* *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	CT/NY Neuro
30II6A-CC	X-rRay	$ 3,818		
30II6A-CC	Oxygen	$ 494		
30II6A-CC	Laboratory	$ 20,498		
30II6A-CC	IV	$ 7,520		
30II6A-CC	Comples Med Equip	$ 14,427		
30II6A-CC	Cont Allowance	$ (40,499)		
Total Other Resident Revenue - Medicare		$ 6,258	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	CT/NY Neuro
30II6b-CCI	X-Ray, Oxygen, Lab, IV	$ 1,387	$ -	$ 26,353
30II6b-CCI	Cont. Allowance	$ (1,026)	$ -	$ (19,489)
Total Other Resident Revenue		$ 361	$ -	$ 6,864

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	CT/NY Neuro
30IV5-CCI	Interest Income		$ 37	$ 1	$ 8
Total Interest Income			$ 37	$ 1	$ 8

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	CT/NY Neuro
30IV8-CCI	Bad Debt Recovery	$ 134,968	$ 3,622	$ 29,568
0	Other Income	$ 1,592	$ 43	$ 349
0	Rent Forgiveness	$ 1,216,666	$ 32,654	$ 266,544
0	Gain on Forgiveness of Debt	$ 2,062	$ 55	$ 452
Total Other Revenue		$ 1,355,288	$ 36,375	$ 296,913

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENT	0723MA	9/30/2019	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 105,234
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,400,337
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 2,566
4 Inventories				$ 17,104
5. Prepaid Expenses				$ 146,192
a. Prepaid Insurance		81,689		
b. Prepaid Workers Comp Ins		14,422		
c. Prepaid Taxes		846		
d. See Schedule		49,235		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 93,544
Net Payroll		23,197		
Employee Loar		742		
Patient Exchange/Exchange other		17,378		
See Schedule		52,227		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,764,977
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost	842,655		$ 286,962
	Accum. Depreciation	555,693	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	1,004,261		$ 264,629
	Accum. Depreciation	739,632	Net	
7. Motor Vehicles	*Historical Cost	51,226		$
	Accum. Depreciation	51,226	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 551,591

* 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	
Pg 31	A5d	Other Prepaid Expenses	$ 49,235
Total Prepaid Expenses			$ 49,235

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

Page Ref	Line Ref	Description	
		Refund-Contra	$ 52,227
Total Other Current Assets (Itemize)			$ 52,227

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	
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	
Pg 33	A12	401K Due	$ 15,782
Total Other Current Liabilities (Itemize)			$ 15,782

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

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
WORCESTER SKILLED CARE CENT	0723MA	9/30/2019	32 | 37

Account				Amount
			Total Brought Forward:	$ 2,316,568
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$ 1,561
2. Escrow Deposits				$ 1,567
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$ 113,630
Name and Address	Amount	Loan Date		
	113,630			
7. Other Assets (*itemize*)				$ 2,400
Construction in Progress		2,400		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 119,158
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 2,435,726

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
WORCESTER SKILLED CARE CENTER, I	0723MA	9/30/2019	33 | 37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 2,191,232
2. Notes Payable (*itemize*)				$ 206,391
N/P-Other		206,391		
See Schedule				
3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 359,464
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 28,170
7. Medicare Final Settlement Payable				$
8. Medicare Current Financing Payable				$
9. Mortgage Payable (*Current Portion*)				$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
11. Accrued Income Taxes*				$
12. Other Current Liabilities (*itemize*)				$ 637,677
Reserve for Medicare Rate Adj	(1,214)	Accrued Prof Svcs	(17,490)	
A/P Patient Trust/PNA	96,485	Deferred Rent	235,184	
Uncashed Checks / Unresolved Cred	16,247	Withheld Life Insurance	(19,858)	
Accrued Expenses	312,541	See Schedule	15,782	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 3,422,934

* 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	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER,	0723MA	9/30/2019	34	37

Account	Amount
Total Brought Forward:	3,422,934
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

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

Name and Address of Lender	Amount	Loan Date

Account	Amount
4. Other Long-Term Liabilities (*itemize*)	$
See Schedule	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 3,422,934

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

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CEN	0723MA	9/30/2019	35	37

Account					Amount
A. **Reserves**					
1. Reserve for value of leased land					$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized					$
3. Reserve for depreciation value of leased personal property (*Equity)*					$
4. Reserve for leasehold real properties on which fair rental value is based					$
5. Reserve for funds set aside as donor restricted					$
6. Total Reserves					$
B. **Net Worth**					
1. Owner's Capital					$
2. Capital Stock					$
3. Paid-in Surplus					$ 3,634,539
4. Treasury Stock					$
5. Cumulated Earnings					$ (5,868,731)
6. Gain or Loss for Period	10/1/2018	thru	9/30/2019		$ 1,246,984
7. Total Net Worth					$ (987,208)
C. ***Total Reserves and Net Worth***					$ (987,208)
D. ***Total Liabilities, Reserves, and Net Worth***					$ 2,435,726

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page | of
WORCESTER SKILLED CARE CENT	0723MA	9/30/2019	36 | 37

	Account			Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2018			$ (2,741,630)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 17,219,275
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 15,972,291
D.	Net Income or Deficit			$ 1,246,984
E.	Balance			$ (1,494,646)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Additional Paid-in Capital	515,547		
	2. Other (*itemize*)			
	Adjustments after filing of 9/30/17 report	(891)		
F-3.	Total Additions			$ 514,656
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$ 7,218
	Name and Address (*No., City, State, Zip*)	Title	Amount	
			7,218	
	2. Other Withdrawings (*Specify*)			$
	Purpose	Amount		
	3. Total Deductions			$ 7,218
H.	***Balance at End of Period*** 09/30/19			$ (987,208)

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE	0723MA	9/30/2019	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
CliftonLarsonAllen LLP		2/4/2020

Printed Name of Preparer	
CLIFTONLARSONALLEN LLP	
Addres Address	Phone Number
300 Crown Colony Dr., Ste 310, Quincy, MA. 02368	617-984-8100
Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
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