State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2018

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 10/1/2017	Report for Year Ending 9/30/2018	

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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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, INC	0723MA	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 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, 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) 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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Department of Social Services
55 Farmington Avenue, Hartford, Connecticut 06105

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Name of Facility WORCESTER SKILLED CARE CENTER, INC	Period Covered:		From 10/1/2017	To 9/30/2018
Address of Facility 59 ACTON STREET ,WORCESTER MA. 01604				
Report Prepared By CLIFTONLARSONALLEN LLP	Phone Number 617-984-8100		Date 3/29/2019	

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

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

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

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

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

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General Information and Questionnaire
Individual Proprietorship

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
WINGATE HEALTHCARE, INC	63 KENDRICK ST., NEEDHAM, MA 02494	⊙	○	10%	MANAGEMENT SERVICES	Page 20,l5j &var	312,794	312,794
WINGATE HEALTHCARE INC	63 KENDRICK ST., NEEDHAM, MA 02494	○	⊙		CENTRAL OFFICE EXPENSE	Page 16, m12	7,450	7,450
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

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

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (*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.

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

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

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

N/A

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
CSI LEASING, INC 9900 OLD OLIVE ST. RD, STE 101, ST LOUIS, MO 63141	○	⊙	EQUIPMENT	FY14	>1 YEAR	7,399	7,399
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total** *** 7,399

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 CLIFTONLARSONALLEN LLP	300 Crown Colony Dr., Ste 310, Quincy, MA 02169
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Audit, Tax & Cost Reporting Services	$ 23,993
2		$
3		$
4		$
		Charge for Services Provided $ 23,993

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

⊙ Yes ○ No — Page 15, Line 1.d

Legal Services Information

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

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	See Attached	$ 3,043
2		$
3		$
4		$
5		$
		Charge for Services Provided $ 3,043

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

⊙ Yes ○ No — Page 15, Line 1.e

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Schedule of Resident Statistics

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	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	145	105	4	36	145	105	4	36	150	109	4	37
B. As of midnight of THIS report period	150	111	4	35	150	109	4	37	150	111	4	35
3. Total Number of Days Care Provided During Period												
A. Medicare	1,280	1,280			787	787			493	493		
B. Medicaid (Conn.)	2,545			2,545	1,874			1,874	671			671
C. Medicaid (other states)	46,202	33,913	1,456	10,833	34,606	25,384	1,088	8,134	11,596	8,529	368	2,699
D. Private Pay	690	690			505	505			185	185		
E. State SSI for RCH												
F. Other (Specify)	2,293	2,293			1,843	1,843			450	450		
G. Total Care Days During Period (3A thru F)	53,010	38,176	1,456	13,378	39,615	28,519	1,088	10,008	13,395	9,657	368	3,370
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	817	813	4		600	596	4		217	217		
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	53,827	38,989	1,460	13,378	40,215	29,115	1,092	10,008	13,612	9,874	368	3,370

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	CT/NY Neuro	R.C.H.	ICF-MR
No. of Residents	9	130		7				
Per Diem Rate								
a. One bed rm.				370.00		.		
b. Two bed rms.				346.00				
c. Three or more bed rms.				333.00				

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

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Report of Expenditures - Salaries & Wages

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

	Total Cost and Hours					
Item	CCNH	Hours	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)	92,972	1,483	3,481	56	31,901	509
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	116,946	5,735	4,379	215	40,127	1,968
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	38,441	1,247	1,439	47	13,190	428
b. Other Maintenance Workers	30,768	1,494	1,152	56	10,557	513
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	45,134	1,507	1,690	56	15,486	517
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	158,934	2,888	5,952	108	54,534	991
b. RN						
1. Direct Care	723,801	18,501	80,122	2,048	734,155	18,765
2. Administrative**	157,659	4,148	5,904	155	54,096	1,423
c. LPN						
1. Direct Care	692,071	23,832	76,609	2,638	701,970	24,173
2. Administrative**						
d. Aides and Attendants	963,638	58,788	106,670	6,508	977,422	59,628
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	56,903	4,346	2,131	163	19,525	1,491
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	29,842	968	1,117	36	10,239	
n. Marketing	56,991	1,822	2,134	68	19,555	
o. Other (Specify)						
See Attached Schedule			119,552	5,920	1,095,461	54,249
A-13. Total Salary Expenditures	3,164,098	126,758	412,334	18,074	3,778,218	164,655

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		CT/NY Neuro	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Salaries- Director of Neurobehavioral			$ 4,763	147	$ 43,646	$ 1,342
Salaires-Behavioral Spec		0	$ 59,740	4,177	$ 547,398	38,275
Salaries-Respiratory Therapy		0	$ 46,815	1,334	$ 428,966	12,219
Salaries - Social Service Neurobehavioral		0	$ 8,234	263	$ 75,451	2,412
Total	$ -	-	$ 119,552	5,920	$ 1,095,461	54,249

Schedule of Other Fees (Page 13)

	CCNH		RHNS		CT/NY Neuro	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Occupational Therapy	$ -	-	$ -	-	$ 156,914	1,846
Total	$ -	-	$ -	-	$ 156,914	1,846

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

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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	CT/NY Neuro							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	CT/NY Neuro							
Section III - Administrators* **										
SUSAN JENNY	92,972	3,481	31,901			2,048	A.2	Administrator		
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total Cost and Hours					
Item	CCNH	Hours	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	14,325	181	536	7	4,915	62
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	19,439	421			58,317	1,264
b. Other						
6. Social Worker	10,275	199	385	7	3,526	68
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	91,267	605	3,418	23	31,316	208
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)						
	21,378	271			64,133	814
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other	49,051	856	5,430	95	49,752	869
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	89,529	1,635	9,910	181	90,810	1,659
b. LPN						
1. Direct Care						
2. Administrative***	211,280	9,603	7,912	360	72,495	3,295
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule					156,914	1,846
B-13 Total Fees Paid in Lieu of Salaries	506,544	13,771	27,591	673	532,178	10,085

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

* 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	9/30/2018	15	37

Item		Total	CCNH	RHNS	CT/NY Neuro
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	133,869	57,593	7,505	68,771
2. Disability Insurance	$				
3. Unemployment Insurance	$				
4. Social Security (F.I.C.A.)	$	668,051	287,407	37,454	343,190
5. Health Insurance	$	508,462	218,749	28,507	261,206
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	13,529	5,820	758	6,950
7. Pensions (Non-Discriminatory)	$	18,148	7,808	1,017	9,323
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	7,885	3,392	442	4,051
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	242,894	175,938	6,588	60,368
d. Accounting and Auditing	$	23,993	17,379	651	5,963
e. Legal (*Services should be fully described on Page 7)*	$	3,643	2,639	99	905
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	34,794	25,203	944	8,648
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	26,816	19,424	727	6,665
2. Cellular Phones	$	812	588	22	202
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	$	1,086,592	787,061	29,473	270,058
Subtotal	$	2,769,488	1,609,001	114,187	1,046,300

* 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	$ 3,392	$ 442	$ 4,051
Total	$ 3,392	$ 442	$ 4,051

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	9/30/2018	16	37

Item		Total	CCNH	RHNS	CT/NY Neuro
Subtotals Brought Forward:		2,769,488	1,609,001	114,187	1,046,300
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	2,552	1,849	69	634
3. Gifts to Staff and Residents	$	785	569	21	195
4. Employee Travel	$	5,084	3,683	138	1,264
5. Education Expenses Related to Seminars and Conventions	$	7,420	5,375	201	1,844
6. Automobile Expense (*not purchase or depreciation*)	$	730	529	20	181
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	12,416	8,993	337	3,086
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	14,401	10,431	391	3,579
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	6,785	4,915	184	1,686
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	25,266	18,301	685	6,280
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions***	$	83	60	2	21
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	319,399	231,353	8,663	79,382
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	211,668	153,319	5,741	52,607
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	3,376,077	2,048,377	130,640	1,197,060

* 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
Marketing	$ 10,431	$ 391	$ 3,579
Total Other Advertising	$ 10,431	$ 391	$ 3,579

Schedule of Dues

Description	CCNH	RHNS	CT/NY Neuro
JCAHO	$ 2,800	$ 105	$ 961
License & Dues -Patient Relatied	$ 13,448	$ 504	$ 4,614
License & Dues- Non Patient related	$ 2,054	$ 77	$ 705
Total Dues	$ 18,301	$ 685	$ 6,280

Schedule of Contributions

Description	CCNH	RHNS	CT/NY Neuro
Donations	$ 60	$ 2	$ 21
Total Contributions	$ 60	$ 2	$ 21

Schedule of Other Administrative and General

Description	CCNH	RHNS	CT/NY Neuro
Physician Care	$ 11,313	$ 424	$ 3,882
Payroll Processing Fees	$ 11,634	$ 436	$ 3,992
Computer Expense	$ 57,808	$ 2,165	$ 19,835
Bookkeeping Service	$ 9,364	$ 351	$ 3,213
Professional Service	$ 26,230	$ 982	$ 9,000
Central Office Expense	$ 5,396	$ 202	$ 1,852
Bank Fees	$ 14,798	$ 554	$ 5,078
Late Charges & Fines & Penalties	$ 16,776	$ 628	$ 5,756
Total Other Administrative and General	$ 153,319	$ 5,741	$ 52,607

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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	312,794	Home Office Services including Accounting, Finance, Nursing, Administration, Operations Mgmt, Human Resources	pg. 16, m12
WINGATE HEALTHCARE INC, 63 KENDRICK ST., NEEDHAM, MA 02494	7,450	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.**

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

Name of Facility	License No.	Report for Year Ended	Page of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2018	18 | 37

Item		Total	CCNH	RHNS	CT/NY Neuro
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$				
2. Non-Food Supplies	$	442	320	12	110
3. Other (*Specify*)_____ Dietary Supplements	$	19,762	14,314	536	4,912
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	882,755	639,414	23,944	219,397
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	902,959	654,048	24,492	224,419

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

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

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

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

Name of Facility	License No.	Report for Year Ended	Page of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2018	19 | 37

Item		Total	CCNH	RHNS	CT/NY Neuro
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $				
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	218,895	39,639	17,638	161,618
c. Other (*Specify*)	$				
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	218,895	39,639	17,638	161,618

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Item			Total	CCNH	RHNS	CT/NY Neuro
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	27,748	20,099	753	6,896
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$	218,895	158,554	5,937	54,404
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	246,643	178,653	6,690	61,300
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$				
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	498,564	361,129	13,523	123,912
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		$	11,447	8,292	310	2,845
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	464,019	65,722		398,297
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	974,030	435,143	13,833	525,054

* 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	$ 340	$ -	$ 6,464
X-ray	$ 205	$ -	$ 3,887
Pharmacy	$ 53,151	$ -	$ 159,453
Complex Medical	$ 9,570	$ -	$ 181,838
Oxygen	$ 1,026	$ -	$ 19,502
Laboratory	$ 946	$ -	$ 17,969
IV	$ 483	$ -	$ 9,185
Total Other Resident Care	$ 65,722	$ -	$ 398,297

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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	9/30/2018	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	CT/NY Neuro	Pg	Line
HEALTHCARE SERVICES GROUP. INC	STE 300 BENSALEM, PA 19020	○	⊙		HOUSEKEEPING SERVICES	158,554	5,937	54,404	20	4b
HEALTHCARE SERVICES GROUP. INC	STE 300 BENSALEM, PA 19020	○	⊙		LAUNDRY SERVICES	39,639	17,638	161,618	19	3b
BULK TV & INTERNET	#100, RALEIGH, NC 27615	○	⊙		CABLE SERVICES	11,053	414	3,792	22	6a
AJ LETOURNEAU, INC	CUTOFF, WORCESTER, MA	○	⊙		WASTE MANAGEMENT	14,698	550	5,043	22	6a
HEALTHCARE SERVICES GROUP. INC	STE 300 BENSALEM, PA 19020	○	⊙		DIETARY SERVICES	639,414	23,944	219,397	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).

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

Name of Facility	License No.	Report for Year Ended	Page of
WORCESTER SKILLED CARE CENTER, I	0723MA	9/30/2018	22 | 37

Item		Total	CCNH	RHNS	CT/NY Neuro
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	172,507	62,476	10,827	99,204
b. Heat	$	53,708	38,903	1,457	13,348
c. Light & Power	$	191,399	138,638	5,191	47,570
d. Water	$	125,801	91,123	3,412	31,266
e. Equipment Lease (*Provide detail on page 6*)	$	7,399	5,359	201	1,839
f. Other (*itemize*)	$	31,759	23,004	861	7,893
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	582,573	359,503	21,949	201,121
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	83,538	60,510	2,266	20,762
c. Non-Movable Equipment	$				
d. Movable Equipment	$	65,388	47,363	1,774	16,251
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	148,926	107,873	4,039	37,014
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$				
9. Rental payments on leased real property less real estate taxes included in item 10b	$	1,448,023	1,048,860	39,276	359,887
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	201,006	145,597	5,452	49,957
c. Personal property taxes	$	21,283	15,416	577	5,290
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,819,238	1,317,745	49,345	452,148

* 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	$ 10,865	$ 407	$ 3,728
Equipment Rental	$ 12,139	$ 455	$ 4,165
Total Other Repairs and Maintenance	$ 23,004	$ 861	$ 7,893

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2018	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	830,468		830,468	387,941	SL	VAR	83,047	
2. Disposals (attach schedule)	(4,316)		(4,316)				(216)	
3. Acquired during this report period (attach schedule)	15,468		15,468				707	
B-4. Subtotal								83,538
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					866,689		866,689	611,670			57,175	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					107,639		107,639				8,213	
D-3. Subtotal												65,388
E. ***Total Depreciation***												148,926

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:					
	SEE ATTACHED	$ 15,468	10	$ 707	
Total additions for Building Improvement		$ 15,468		$ 707	*
Deletions:					
	SEE ATTACHED	$ (4,316)		$ (216)	
Total deletions for Building Improvement		$ (4,316)		$ (216)	**

***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	$ 107,639	VAR	$ 8,213	
Total additions for Movable Equipmen		$ 107,639		$ 8,213	*
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 Improvemer		$ -		$ -	*
Deletions:					
Total deletions for Leasehold Improvemer		$ -		$ -	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
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Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									

* Straight-line method must be used.

** Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.
B. Life of mortgage; OR
C. Remaining Life of Lease; OR
D. Actual Life if owned by Related Party.

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

Name of Facility	License No.	Report for Year Ended	Page	of
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11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	
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
Sabra Health Care REIT, Inc. 18500 Von Karman Avenue Ste 550. Irvine, CA 92612	Land & Building	01/31/06	1/31/06-2/1/20	1,448,023

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 CEI	0723MA	9/30/2018	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	9/30/2018	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*)		$	19,221	13,923	521	4,777
Interest on working capital						
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)		$	19,221	13,923	521	4,777
14. Insurance						
a. Insurance on Property (buildings only)		$	11,808	8,553	320	2,935
b. Insurance on Automobiles		$				
c. Insurance other than Property (as specified above)						
1. Umbrella (*Blanket Coverage*)		$	136,293	98,722	3,697	33,874
2. Fire and Extended Coverage		$				
3. Other (*Specify*)		$				
14d. ***Total Insurance Expenditures (14a + b + c)***		$	148,101	107,275	4,017	36,809
15. ***Total All Expenditures (A-13 thru C-14)***		$	16,708,699	8,824,948	709,050	7,174,701

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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	9/30/2018	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	$	78,680	56,991	2,134	19,555
3.	10	12.g.	Occupational Therapy	$				
4.			Other - See attached Schedule	$				
Page 13 - Professional Fees								
5.			Resident Care Physicians **	$				
6.			Occupational Therapy	$				
7.			Other - See attached Schedule	$				
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.	15	1.c	Bad Debts	$	242,894	175,938	6,588	60,368
10.	15	1.e	Accounting	$				
10a.			Legal	$				
11.			Telephone	$				
12.	15	1.h.2	Cellular Telephone	$	812	588	22	202
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	m3	Unallowable Advertising *	$	14,401	10,431	391	3,579
19.			Income Tax / Corporate Business Tax	$				
20.			Fund Raising / Contributions	$	83	60	2	21
21.			Unallowable Management Fees	$				
22.	30	IV7	Barber and Beauty	$				
23.			Other - See attached Schedule	$	40,159	24,922	1,499	13,737
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)	$	377,029	268,930	10,636	97,462

* 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	$ 6,093	$ 794	$ 7,276
16	M13	Late Charges & Fines & Penalties	$ 16,776	$ 628	$ 5,756
16	M8	License & Dues- Non Patient related	$ 2,054	$ 77	$ 705
Total Other A&G Adjustments			$ 24,922	$ 1,499	$ 13,737

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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	9/30/2018	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	CT/NY Neuro
			Subtotals Brought Forward $	377,029	268,930	10,636	97,462
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 $	464,019	65,722		398,297
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.	30	IV, 8	Other - Miscellaneous Administrative $	1,072	777	29	266
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)*** $	842,120	335,429	10,665	496,025

*** 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	$ 340	$ -	$ 6,464
		X-ray	$ 205	$ -	$ 3,887
		Pharmacy	$ 53,151	$ -	$ 159,453
		Complex Medical	$ 9,570	$ -	$ 181,838
		Oxygen	$ 1,026	$ -	$ 19,502
		Laboratory	$ 946	$ -	$ 17,969
		IV	$ 483	$ -	$ 9,185
Total Other Ancillary Costs			$ 65,722	$ -	$ 398,297

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 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			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTE	0723MA	9/30/2018	30	37

Item		Total	CCNH	RHNS	CT/NY Neuro
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	1,012,605			1,012,605
b. Medicaid Room and Board Contractual Allowance **	$				
2. a. Medicaid (*All other states*)	$	12,550,916	9,091,119	340,430	3,119,367
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	784,492	784,492		
b. Medicare Room and Board Contractual Allowance **	$				
4. a. Private-Pay Residents and Other	$	1,238,100	1,238,100		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	137,274	137,274		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(137,274)	(137,274)		
c. Prescription Drugs - Non-Medicare	$	14,613	3,653		10,960
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(14,245)	(3,561)		(10,684)
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	$	139,379	139,379		
b. Physical Therapy - Medicare Contractual Allowance **	$	(90,759)	(90,759)		
c. Physical Therapy - Non-Medicare	$	14,895	3,724		11,171
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(11,499)	(2,875)		(8,624)
4. a. Speech Therapy - Medicare	$	174,066	174,066		
b. Speech Therapy - Medicare Contractual Allowance **	$	(104,851)	(104,851)		
c. Speech Therapy - Non-Medicare	$	25,634	6,409		19,226
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(23,663)	(5,916)		(17,747)
5. a. Occupational Therapy - Medicare	$	387,044	387,044		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(253,438)	(253,438)		
c. Occupational Therapy - Non-Medicare	$	63,777	15,944		47,833
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(49,839)	(12,460)		(37,379)
6. a. Other *(Specify)* - Medicare	$	3,078	3,078		
b. Other *(Specify)* - Non-Medicare	$	7,949	397		7,552
III. *Total Resident Revenue* (Section I. thru Section II.)	$	15,868,254	11,373,546	340,430	4,154,278
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)*	$	225	163	6	56
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	1,518	1,100	41	377
V. Total Other Revenue (1 thru 8)	$	1,743	1,263	47	433
VI. Total All Revenue (III +V)	$	15,869,997	11,374,809	340,477	4,154,711

* *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		$ 13,447	$ -	$ -
30II6A-CC	Oxygen		$ 1,364	$ -	$ -
30II6A-CC	Laboratory		$ 15,225	$ -	$ -
30II6A-CC	IV		$ 7,195	$ -	$ -
30II6A-CC	Cont Allowance		$ (34,153)	$ -	$ -
0		0	$ -	$ -	$ -
Total Other Resident Revenue - Medicare			$ 3,078	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	CT/NY Neuro
30II6b-CC	X-Ray, Oxygen, Lab, IV	$ 1,387	$ -	$ 26,350
30II6b-CC	Cont. Allowance	$ (989)	$ -	$ (18,799)
Total Other Resident Revenue		$ 397	$ -	$ 7,552

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	CT/NY Neuro
30IV5-CC	Interest Income		$ 163	$ 6	$ 56
Total Interest Income			$ 163	$ 6	$ 56

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	CT/NY Neuro
30IV8-CC	Bad Debt Recovery	$ 323	$ 12	$ 111
0	Other Income	$ 777	$ 29	$ 266
Total Other Revenue		$ 1,100	$ 41	$ 377

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENT	0723MA	9/30/2018	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 12,891
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,358,153
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 3,523
4 Inventories				$ 17,104
5. Prepaid Expenses				$ 120,780
a.				
b.				
c.				
d. See Schedule		120,780		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 74,317
See Schedule		74,317		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,586,768
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost	841,620		$ 370,141
	Accum. Depreciation	471,479	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	974,328		$ 297,270
	Accum. Depreciation	677,058	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)				$ 667,411

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENT	0723MA	9/30/2018	32	37

Account				Amount
			Total Brought Forward:	$ 2,254,179
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				$ (24,189)
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*)				$ (193,892)
Name and Address	Amount	Loan Date		
	(193,892)			
7. Other Assets (*itemize*)				$ 2,400
See Schedule	2,400			
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ (214,120)
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 2,040,059

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

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
		PREPAID WORKERS COMP INS	$ 79,682
		PREPAID TAXES	$ 846
		OTHER PREPAID EXPESNES	$ 40,252
Total Prepaid Expenses			$ 120,780

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

Page Ref	Line Ref	Description	
		NET PAYROLL	$ 15,770
		EMPLOYEE LOAN	$ 742
		PATIENT EXCHANGE / EXCHANGE OTHER	$ 17,378
		REFUND-CONTRA	$ 40,427
Total Other Current Assets (Itemize)			$ 74,317

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	
		CONSTRUCTION IN PROGRESS	$ 2,400
Total Other Assets			$ 2,400

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
		N/P - OTHER	$ 310,943
Total Notes Payable			$ 310,943

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

Page Ref	Line Ref	Description	
		Reserve for Medicare Rate Adj	$ (1,214)
		A/P Patirent Trust PNA	$ 103,106
		Unncashed Checks	$ 1,024
		Accruest Expenses= 1281453 Accrued Prof. Services = -17089	1264364
		Deferred Rent	405523
		W/H Life Ins = -8553 401K Due = 6764	-1789
Total Other Current Liabilities (Itemize)			$ 1,771,014

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

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

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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	9/30/2018	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 2,345,783
	2. Notes Payable (*itemize*)				$ 310,943
	See Schedule			310,943	
	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*)				$ 330,038
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 23,911
	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*)				$ 1,771,014
	See Schedule			1,771,014	
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 4,781,689

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER,	0723MA	9/30/2018	34	37

Account	Amount
Total Brought Forward:	4,781,689
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

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

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$
See Schedule	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 4,781,689

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

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CEN	0723MA	9/30/2018	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 (*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	$ 3,118,993
4.	Treasury Stock	$
5.	Cumulated Earnings	$ (5,021,924)
6.	Gain or Loss for Period 10/1/2017 thru 9/30/2018	$ (838,699)
7.	Total Net Worth	$ (2,741,630)
C.	***Total Reserves and Net Worth***	$ (2,741,630)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 2,040,059

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENT	0723MA	9/30/2018	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2017			$ (2,209,436)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 15,869,997
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 16,708,696
D.	Net Income or Deficit			$ (838,699)
E.	Balance			$ (3,048,135)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Additional Paid In Capital		306,505	
	2. Other (*itemize*)			
F-3.	Total Additions			$ 306,505
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period***	09/30/18		$ (2,741,630)

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

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE	0723MA	9/30/2018	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		2/13/2019

Printed Name of Preparer	
CLIFTONLARSONALLEN LLP	
Addres Address	Phone Number
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