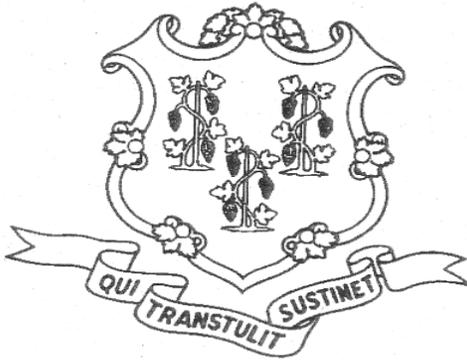


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2015

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 <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;">                     Chronic and Convalescent  <input checked="" type="checkbox"/> Nursing Home only (CCNH)                 </div> <div style="width: 30%;">                     Rest Home with Nursing  <input type="checkbox"/> Supervision only (RHNS)                 </div> <div style="width: 30%;"> <input checked="" type="checkbox"/> Other                 </div> </div>	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH 0723MA	RHNS	Other	Medicare Provider 225219
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Medicaid Provider Numbers:	CCNH 26450	RHNS	ICF-IID
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**For Department Use Only**

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

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### General Information

Name of Facility (as licensed) WORCESTER SKILLED CARE CENTER, INC	License No. 0723MA	Report for Year Ended 9/30/2015	Page 1	of 37
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#### Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for WORCESTER SKILLED CARE CENTER, INC [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, 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) SUE GAUTHIER			Printed Name (Owner) BRIAN CALLAHAN		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility WORCESTER SKILLED CARE CENTER, INC		Period Covered:	From 10/1/2014	To 9/30/2015
Address of Facility 59 ACTON STREET, WORCESTER , MA, 01604				
Report Prepared By CLIFTONLARSONALLEN LLP		Phone Number 617-984-8100	Date	
Item	Total	CCNH	RHNS	Other
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (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.**

**General Information and Questionnaire**  
**Type of Facility - Organization Structure**

Phone No. of Facility 508-791-3147		Report for Year Ended 9/30/2015		Page 2	of 37
Name of Facility (as shown on license) WORCESTER SKILLED CARE CENTER, INC			Address (No. & Street, City, State, Zip) 59 ACTON STREET, WORCESTER, MA, 01604		
License Numbers:	CCNH 0723MA	MA Neuro	CT/NY Neuro	Medicare Provider No. 225219	
Type of Facility (Check appropriate box(es))					
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input checked="" type="checkbox"/> Other	
Type of Ownership (Check appropriate box)					
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust					
If this facility opened or closed during report year provide:			Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No   If "Yes," explain fully.					
<b>Administrator</b>					
Name of Administrator SUE GAUTHIER			Nursing Home Administrator's License No.:	5216 NH (Massachusetts)	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		



**General Information and Questionnaire**  
**Corporate Owners**

Name of Facility WORCESTER SKILLED CARE CENTER,	License No. 0723MA	Report for Year Ended 9/30/2015	Page 3A	of 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 RESIDENTAL CARE WORCESTER, INC	63 KENDRICK ST., NEEDHAM, MA 02494	MASSACHU SETTS		
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	



### General Information and Questionnaire Related Parties\*

Name of Facility WORCESTER SKILLED CARE CENTER, INC	License No. 0723MA	Report for Year Ended 9/30/2015	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?  Yes  No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
WEST RIVER PHARMACY UBC	140 LOCKE DR., MARLBORO, MA 01752	<input checked="" type="radio"/>	<input type="radio"/>	10%	PHARMACY SERVICES	Page 20 L5J & Var	564,244	564,244
WINGATE HEALTHCARE, INC	63 KENDRICK ST., NEEDHAM, MA 02494	<input type="radio"/>	<input checked="" type="radio"/>		MANAGEMENT SERVICES	Page 16, Line M12	714,550	714,550
WINCATE HEALTHCARE INC	63 KENDRICK ST., NEEDHAM, MA 02494	<input type="radio"/>	<input checked="" type="radio"/>		COMPUTER SERVICES	Page 16, Line M13	18,000	18,000
WINGATE HEALTHCARE INC	63 KENDRICK ST., NEEDHAM, MA 02494	<input type="radio"/>	<input checked="" type="radio"/>		CENTRAL OFFICE EXPENSE	Page 16, Line M13	48,472	47,472
SENIOR RESIDENTIAL CARE WORCESTER	63 KENDRICK ST., NEEDHAM, MA 02494	<input type="radio"/>	<input checked="" type="radio"/>		LICENSE FEE	Page 16, Line M13	24,996	24,996
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					

\* Use additional sheets if necessary.

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

## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility <b>WORCESTER SKILLED CARE CENTER, IN</b>	License No. <b>0723MA</b>	Report for Year Ended <b>9/30/2015</b>	Page <b>5</b>	of <b>37</b>
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

1. In the preparation of this Report, were all costs allocated as required?  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, cost are allocated between non neurobehavioral residents (CCH" heading is 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 report). Nursing costs are allocated by applying facility staffing FTE's (3.2 for CCH, 3.6 for Neuro) to resident days for each column; ancillary costs are allocated based on estimated percentage of residents receiving the services (rehab services: 25% CCH, 75% CT/NY Neuro, non rehab ancillaries: 5% CCH, 95% CT/NY Neuro); specific neurobehavioral salaries & other costs are allocated between MA Neuro & CT/NY Neuro based on resident days for those categories. All other costs are allocated among the three columns based on resident days. The behavioral residents were broken out into 2 columns because CT/NY are all inclusive rates which include all ancillary services. MA is not all inclusive and all ancillary services are billed by a third party.

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

Pharmacy services, computer services and therapy services 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

## 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	9/30/2015			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	<input type="radio"/>	<input checked="" type="radio"/>	EQUIPMENT	FY14	>1 YEAR	17,391	17,391	
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
<b>Total ***</b>							17,391	

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes       No

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

## General Information and Questionnaire

### Accounting Basis

Name of Facility WORCESTER SKILLED CARE C	License No. 0723MA	Report for Year Ended 9/30/2015	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual     Cash     Modified Cash

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

**Independent Accounting Firm**

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

Services Provided by This Firm (*describe fully*)

1 AUDIT, TAX & COST REPORTING SERVICES	\$	39,925
2	\$	
3	\$	
4	\$	
		Charge for Services Provided
		\$ 39,925

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

Yes     No    Page 15, Line 1D

**Legal Services Information**

Name of Legal Firm or Independent Attorney 1 Erin Bradbury, Esq. 2 Jeffrey A Cohen & Assoc 3 Jeffrey P Campbell 4 Tucker Saltzman & Dyer LLP 5 SCIACCA LAW GROUP, LLC	Telephone Number 508-791-8500 781-431-2231 508-864-3357 617-986-6220 617-769-5215
--	--

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

1	880 Main St#220, Holden, Ma 01520
2	110 Cedar Srt., Wellesley, MA 02481
3	32 Cedar St.,#303, Worcester, MA 01609
4	50 Congress St., Bosotn, MA 02109
5	17 Canton Ave. Milton, MA 02186

Services Provided by This Firm (*describe fully*)

1 Accounts Receivable Issues	\$	25,814
2 Accounts Receivable Issues	\$	14,588
3 Rogers Guardianship Review	\$	11,200
4 Legal Consulting	\$	1,372
5 Rogers Guardianship Review	\$	3,565
		Charge for Services Provided
		\$ 56,539

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

Yes     No

**Schedule of Resident Statistics**

Name of Facility WORCESTER SKILLED CARE CENTER, INC			License No. 0723MA			Report for Year Ended 9/30/2015			Page 8	of 37		
	Total All Levels	Total CCNH Level	Total MA Neuro Level	CT/NY Neuro	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	MA Neuro	CT/NY Neuro	Total	CCNH	MA Neuro	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	160	104	5	51	160	104	5	51	156	99	5	52
B. As of midnight of THIS report period	156	105	5	46	165	112	5	48	156	105	5	46
3. Total Number of Days Care Provided During Period												
A. Medicare	969	969			895	895			74	74		
B. Medicaid (Conn.)	3,949			3,949	3,030			3,030	919			919
C. Medicaid (other states)	36,452	34,634	1,818		26,801	25,440	1,361		9,651	9,194	457	
D. Private Pay	569	569			477	477			92	92		
E. State SSI for RCH												
F. Other (Specify) NY/NJ Medicaid -HMO	16,543	6,697		9,846	12,569	5,108		7,461	3,974	1,589		2,385
G. Total Care Days During Period (3A thru F)	58,482	42,869	1,818	13,795	43,772	31,920	1,361	10,491	14,710	10,949	457	3,304
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	882	873	7	2	671	665	4	2	211	208	3	
B. Other Bed Reserve Days												
5. <b>Total Resident Days (3G + 4A + 4B)</b>	59,364	43,742	1,825	13,797	44,443	32,585	1,365	10,493	14,921	11,157	460	3,304

### Schedule of Resident Statistics (Cont'd)

Name of Facility WORCESTER SKILLED CARE CENTER,			License No. 0723MA			Report for Year Ended 9/30/2015			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	Other	Lost			Gained			CCNH	RHNS	Other	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days								CCNH	RHNS	Other			
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	Other	R.C.H.	ICF-MR				
No. of Residents			154		2								
Per Diem Rate													
a. One bed rm.	607.59												
b. Two bed rms.	541.45												
c. Three or more bed rms.	535.95												
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	MA Neuro	CT/NY Neuro		
A. Medicare - Part B								1,732	433		1,299		
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								115	29		86		
C. Other								2,043	511		1,532		
D. <b>Total Physical Therapy Treatments</b>								3,890	973		2,918		
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								821	205		616		
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								9	2		7		
C. Other								1,753	438		1,315		
D. <b>Total Speech Therapy Treatments</b>								2,583	646		1,937		
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								1,291	323		968		
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								34	9		26		
C. Other								3,053	611		2,443		
D. <b>Total Occupational Therapy Treatments</b>								4,378	942		3,437		

### Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2015	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	MA Neuro	Hours	CT/NY Neuro	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	93,754	1,527	3,912	64	29,572	482
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	180,301	9,946	7,523	415	56,870	3,137
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	46,918	1,399	1,958	58	14,799	441
b. Other Maintenance Workers	31,734	1,670	1,324	70	10,009	527
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	43,986	2,019	1,835	84	13,874	637
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	141,615	3,059	5,908	128	44,668	965
b. RN						
1. Direct Care	877,376	26,526	115,309	3,486	871,739	26,355
2. Administrative**	134,147	3,991	5,597	167	42,312	1,259
c. LPN						
1. Direct Care	610,615	21,655	80,250	2,846	606,691	21,516
2. Administrative**						
d. Aides and Attendants	1,138,528	82,705	149,631	10,870	1,131,213	82,174
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	61,081	5,109	2,548	213	19,266	1,611
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	38,471	1,466	1,605	61	12,135	462
n. Marketing	56,282	1,533	2,348	64	17,752	483
o. Other (Specify)						
See Attached Schedule	362,898	10,592	108,960	7,114	823,734	53,781
A-13. Total Salary Expenditures	3,817,707	173,195	488,708	25,639	3,694,635	193,830

\* 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		MA Neuro		CT/NY Neuro	
	\$	Hours	\$	Hours	\$	Hours
Director of Neurobehavior			\$ 9,830	241	\$ 74,312	1,824
Behavioral Specialists			\$ 87,206	6,401	\$ 659,279	48,390
Respiratory Therapist	\$ 362,898	10,592				
Social Service Neurobehavioral			\$ 11,924	472	\$ 90,143	3,567
<b>Total</b>	\$ 362,898	10,592	\$ 108,960	7,114	\$ 823,734	53,781

Schedule of Other Fees (Page 13)

Service	CCNH		MA Neuro		CT/NY Neuro	
	\$	Hours	\$	Hours	\$	Hours
Psychiatric Consultant					\$ 23,960	149
Nurse Practioner	\$ 11,006	127	\$ 459	5	\$ 3,471	40
Occupational Therapy					\$ 146,756	1,632
Note: Occupational Therapy has not been disallowed because Worcester Skilled Care's contract with the State of Connecticut is an all inclusive rate which includes all ancillary services.						
<b>Total</b>	\$ 11,006	127	\$ 459	5	\$ 174,187	1,821

**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	9/30/2015				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	Other							
<b>Section I - Operators/Owners</b>										
<b>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).</b>										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
WORCESTER SKILLED CARE CENTER, INC				0723MA	9/30/2015			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	MA Neuro	CT/NY Neuro							
<b>Section III - Administrators***</b>										
SUE GAUTHIER	93,754	3,912	29,572		Administrator	2,073	A2			
<b>Section IV - Assistant Administrators</b>										

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

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

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

**B. Report of Expenditures - Professional Fees**

Name of Facility	License No.	Report for Year Ended	Page	of		
WORCESTER SKILLED CARE CENTER, INC	0723MA	9/30/2015	13	37		
<b>Total Cost and Hours</b>						
Item	CCNH	Hours	MA Nuero	Hours	CT/NY Neuro	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian						
2. Dentist						
3. Pharmacist	18,356	203	766	8	5,790	64
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	40,173	460			120,519	1,380
b. Other						
6. Social Worker	7,734	124	323	5	2,439	39
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	80,169	550	3,345	23	25,287	174
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) Other Phys/Psych Rounds						
9. Speech Therapist						
a. Resident Care	25,853	272			77,558	816
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	2,578	50	339	7	2,562	50
2. Administrative***						
b. LPN						
1. Direct Care	22,379	491	2,941	65	22,236	488
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	11,006	127	459	5	174,187	1,821
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>208,248</b>	<b>2,279</b>	<b>8,173</b>	<b>113</b>	<b>430,578</b>	<b>4,832</b>

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

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

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

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

Name of Facility WORCESTER SKILLED CARE CENTER, INC		License No. 0723MA		Report for Year Ended 9/30/2015	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
WEST RIVER PHARMACY	PHARMACY CONSULTING	<input checked="" type="radio"/>	<input type="radio"/>	COMMON OWNERSHIP		
HEALTH DRIVE PODIATRY	FOOT CARE	<input type="radio"/>	<input checked="" type="radio"/>			
REHAB CARE	PT THERAPIST	<input type="radio"/>	<input checked="" type="radio"/>			
WILLIAM H. JOHNSON	SOCIAL WORKER	<input type="radio"/>	<input checked="" type="radio"/>			
MICHAEL C. RANDON, MD	MEDICAL DIRECTOR	<input type="radio"/>	<input checked="" type="radio"/>			
THOMAS PATNAUDE, MD	MEDICAL DIRECTOR	<input type="radio"/>	<input checked="" type="radio"/>			
DANIEL TANENBAUM, MD	PHYSICIAN	<input type="radio"/>	<input checked="" type="radio"/>			
REHAB CARE	ST THERAPIST	<input type="radio"/>	<input checked="" type="radio"/>			
REHAB CARE	OT THERAPIST	<input type="radio"/>	<input checked="" type="radio"/>			
WM, INC	NURSE PRACTITIONER	<input type="radio"/>	<input checked="" type="radio"/>			
WEST CENTRAL FAMILY	PSYCHIATRIC SERVICES	<input type="radio"/>	<input checked="" type="radio"/>			
ANTHONY B. JOSEPH, MD	PSYCHIATRIC CONSULTANT	<input type="radio"/>	<input checked="" type="radio"/>			
DR. BLUE	UROLOGY SERVICES	<input type="radio"/>	<input checked="" type="radio"/>			
HEALTH DRIVE EYE CARE GROUP	EYE CARE	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			

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

**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	9/30/2015		15	37
Item	Total	CCNH	MA Neuro	CT/NY Neuro	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 144,794	69,089	8,844	66,861	
2. Disability Insurance	\$				
3. Unemployment Insurance	\$				
4. Social Security (F.I.C.A.)	\$ 720,737	343,900	44,023	332,814	
5. Health Insurance	\$ 493,538	235,492	30,146	227,900	
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 25,051	11,953	1,530	11,568	
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 1,777	848	109	821	
8. Uniform Allowance	\$				
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 19,224	9,173	1,174	8,877	
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 95,203	70,150	2,927	22,126	
d. Accounting and Auditing	\$ 39,925	29,418	1,227	9,279	
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 56,539	41,660	1,738	13,140	
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$				
g. Office Supplies	\$ 81,421	59,995	2,503	18,923	
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 27,283	20,103	839	6,341	
2. Cellular Phones	\$ 1,227	904	38	285	
i. Appraisal ( <i>Specify purpose and         attach copy</i> )*	\$				
j. Corporation Business Taxes ( <i>franchise tax</i> )	\$				
k. Other Taxes ( <i>Not related to property - See Page 22</i> )					
1. Income*	\$ 444	327	14	103	
2. Other ( <i>Specify</i> ) See Attached Schedule	\$ 903	665	28	210	
3. Resident Day User Fee	\$ 1,069,106	787,764	32,867	248,475	
<b>Subtotal</b>	\$ 2,777,172	1,681,442	128,006	967,724	

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

(Carry Subtotals forward to next page)



**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	9/30/2015		16	37
Item	Total	CCNH	MA Neuro	CT/NY Neuro	
<b><i>Subtotals Brought Forward:</i></b>	2,777,172	1,681,442	128,006	967,724	
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 2,229	1,642	69	518	
3. Gifts to Staff and Residents	\$ 1,800	1,326	55	418	
4. Employee Travel	\$ 8,658	6,380	266	2,012	
5. Education Expenses Related to Seminars and Conventions	\$ 6,507	4,795	200	1,512	
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$ 4,249	3,131	131	988	
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$ 13,251	9,764	407	3,080	
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ 10,070	7,420	310	2,340	
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 7,303	5,381	225	1,697	
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 25,450	18,753	782	5,915	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$ 200	147	6	46	
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$				
12. Administrative Management Services**	\$ 714,550	526,512	21,967	166,071	
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 238,682	163,273	8,809	66,600	
<b><i>C-14 Total Administrative &amp; General Expenditures</i></b>	\$ 3,810,121	2,429,965	161,233	1,218,922	

\* Do not include Subscriptions, which should go in item 9.

\*\* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

**Schedule of Other Travel and Entertainment**

Description	CCNH	MA Neuro	CT/NY Neuro
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -

**Schedule of Other Advertising**

Description	CCNH	MA Neuro	CT/NY Neuro
Advertising Promotional	\$ 7,420	\$ 310	\$ 2,340
<b>Total Other Advertising</b>	\$ 7,420	\$ 310	\$ 2,340

**Schedule of Dues**

Description	CCNH	MA Neuro	CT/NY Neuro
JCAHO	\$ 1,043	\$ 44	\$ 329
License & Dues-Patient Related	\$ 17,710	\$ 739	\$ 5,586
<b>Total Dues</b>	\$ 18,753	\$ 782	\$ 5,915

**Schedule of Contributions**

Description	CCNH	MA Neuro	CT/NY Neuro
Donations	\$ 147	\$ 6	\$ 46
<b>Total Contributions</b>	\$ 147	\$ 6	\$ 46

**Schedule of Other Administrative and General**

Description	CCNH	MA Neuro	CT/NY Neuro
Physician Care	\$ 6,549	\$ 273	\$ 2,066
Payroll Processing Fees	\$ 14,734	\$ 615	\$ 4,647
Computer Expense	\$ 45,969	\$ 1,918	\$ 14,500
Bookkeeping Service	\$ 6,074	\$ 253	\$ 1,916
Professional Service	\$ 10,464	\$ 437	\$ 3,301
Central Office Expense	\$ 35,716	\$ 1,490	\$ 11,266
Bank Fees		\$ 1,997	\$ 15,101
Purchase Service General	\$ 8,015	\$ 334	\$ 2,528
License Fee	\$ 18,418	\$ 768	\$ 5,809
Late Charges	\$ 16,939	\$ 707	\$ 5,343
Miscellaneous Expense	\$ 394	\$ 16	\$ 124
<b>Total Other Administrative and General</b>	\$ 163,273	\$ 8,809	\$ 66,600

**Schedule C-1 - Management Services\***

Name of Facility	License No.	Report for Year Ended	Page of
WORCESTER SKILLED CARE CENTE	0723MA	9/30/2015	17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Wingate Healthcare, Inc., 63 Kendrick St., Needham MA 02494	714,550	Home Office Sevices including Accounting, Finance, Nursing Admin, Operations Mgmt, Human Resources	Page 16, M12
Wingate Healthcare, Inc., 63 Kendrick St., Needham MA 02494	48,472	Central Office Expense	Page 16, M13
Wingate Healthcare, Inc., 63 Kendrick St., Needham MA 02494	18,000	Computer Services	Page 16, M13
West River Pharmacy, 140 Locke Drive, Marlboro, MA 01752	564,244	Pharmacy Services	Page 20 L5J, Page 13 LB3 & various
Senior Residential Care Worcester, Inc., 63 Kendrick St., Needham, MA 02494	24,996	License Fee	Page 16, Line 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 WORCESTER SKILLED CARE CENTER, INC	License No. 0723MA	Report for Year Ended 9/30/2015	Page 18	of 37
Item	Total	CCNH	MA Neuro	CT/NY Neuro
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 540	398	17	126
2. Non-Food Supplies	\$ 6,253	4,607	192	1,453
3. Other ( <i>Specify</i> ) _____ Dietary Supplementals	\$ 39,495	29,102	1,214	9,179
b. Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )	\$ 853,407	628,828	26,236	198,343
c. Management Services**	\$			
d. Other ( <i>Specify</i> ) _____	\$			
<b>2E. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 899,695</b>	<b>662,935</b>	<b>27,659</b>	<b>209,101</b>
2F. Dietary Questionnaire	Total	CCNH	MA Neuro	CT/NY Neuro
G. Resident Meals: Total no. of meals served per day:*				
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No				
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify amt.				
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify cost.				
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify amt.				
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify cost.				
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify amt.				
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

\* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.  
 \*\* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Name of Facility WORCESTER SKILLED CARE CENTER, INC		License No. 0723MA	Report for Year Ended 9/30/2015		Page 19	of 37
Item		Total	CCNH	MA Neuro	CT/NY Neuro	
3. Laundry						
a. In-House Processing*		Lbs.				
1.	Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	426	314	13	99
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)	\$	183,798	33,305	17,581	132,912
c.	Management Services**	\$				
d.	Other (Specify)	\$				
<b>3E. Total Laundry Expenditures (3a + b + c + d)</b>		\$	184,224	33,619	17,594	133,011
3F. Laundry Questionnaire						
G.	Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
H.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
I.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
L.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

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

\*\* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

**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	9/30/2015	20	37	
Item		Total	CCNH	MA Neuro	CT/NY Neuro
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care					
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	28,569	21,051	878	6,640
b. Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )	Sq. Ft. Serviced by Personnel				
	Amt. \$	183,798	135,430	5,650	42,717
c. Management Services*	\$				
d. Other ( <i>Specify</i> )	\$				
<b>4E. Total Housekeeping Expenditures (4a + b + c + d)</b>	\$	212,367	156,481	6,529	49,357
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$				
b. Medicine Cabinet Drugs	\$				
c. Medical and Therapeutic Supplies	\$	477,085	351,537	14,667	110,881
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$				
f. X-rays and Related Radiological Procedures***	\$				
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$				
i. Recreation	\$	13,253	9,765	407	3,080
j. Other ( <i>Specify</i> )**** See Attached Schedule	\$	638,578	128,833		509,746
<b>5K. Total Resident Care Expenditures (5a - 5j)</b>	\$	1,128,916	490,135	15,074	623,707

\* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

\*\* Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

\*\*\* Facility should self-disallow the expense on Page 29 of the Cost Report.

\*\*\*\* ICFMR's should provide a detailed schedule of all Day Program Costs.



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

Name of Facility WORCESTER SKILLED CARE CENTER, INC			License No. 0723MA		Report for Year Ended 9/30/2015				Page of 21   37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	MA Neuro	CT/NY Neuro	Pg	Line
HEALTHCARE SERVICES GROUP, INC	STE 300 BENSLEM, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		HOUSEKEEPING SERVICES	135,430	5,650	42,717	20	4b
HEALTHCARE SERVICES GROUP, INC	STE 300 BENSLEM, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		LAUNDRY SERVICES	33,305	17,581	132,912	19	3b
BULK TV & INTERNET	#100, RALEIGH, NC 27615	<input type="radio"/>	<input checked="" type="radio"/>		CABLE SERVICES	11,171	466	3,524	22	6a
AJ LETOURNEAU, INC	CUTOFF, WORCESTER, MA	<input type="radio"/>	<input checked="" type="radio"/>		WASTE MANAGEMENT	14,938	623	4,712	22	6a
HEALTHCARE SERVICES GROUP, INC	STE 300 BENSLEM, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		DIETARY SERVICES	628,828	26,236	198,343	18	2b
EAGLE ELEVATOR CO, INC	AVENUE, BOSTON, MA 02119	<input type="radio"/>	<input checked="" type="radio"/>		MAINTENANCE SERVICES	11,855	495	3,739	22	6a
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							

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

### 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	9/30/2015			22	37
Item	Total	CCNH	MA Neuro	CT/NY Neuro		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 274,086	100,979	20,223	152,884		
b. Heat	\$ 50,732	37,382	1,560	11,791		
c. Light & Power	\$ 155,124	114,302	4,769	36,053		
d. Water	\$ 96,529	71,127	2,968	22,435		
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 17,391	12,814	535	4,042		
f. Other ( <i>itemize</i> )	\$ 30,509	22,480	938	7,091		
See Attached Schedule						
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$ 624,371	359,085	30,991	234,295		
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$					
b. Building & Building Improvements	\$ 59,453	43,808	1,828	13,818		
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 80,988	59,676	2,490	18,823		
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$ 140,441	103,483	4,318	32,640		
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other ( <i>Specify</i> )	\$					
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 1,550,081	1,142,168	47,653	360,260		
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 245,750	181,079	7,555	57,116		
c. Personal property taxes	\$ 20,239	14,913	622	4,704		
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$ 1,956,511	1,441,643	60,148	454,720		

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

**Schedule of Other Repairs and Maintenance**

Description	CCNH	MA Neuro	CT/NY Neuro
Rent-Other	\$ 10,132	\$ 423	\$ 3,196
Equipment Rental	\$ 12,349	\$ 515	\$ 3,895
<b>Total Other Repairs and Maintenance</b>	\$ 22,480	\$ 938	\$ 7,091

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WORCESTER SKILLED CARE CENTER, INC  
9/30/2015

Schedule of Land Improvements Acquired during this report period

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

\*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
<b>Additions:</b>				
12/5/2014	COMPASS FLOORING-COVE BASE VARIOUS ROOMS	\$ 1,614	10	\$ 61
10/15/2014	WJS MECHANICAL BOILER CONTROL	\$ 2,083	20	\$ 39
1/8/2015	ANTHONY CONTRACTING WALL COVERINGS	\$ 18,000	10	\$ 675
4/3/2015	COMPASS FLOORING - ELEVATOR FLOORING	\$ 2,117	10	\$ 79
2/11/2015	WJS MECHANICAL -DAIKIN CHILLER	\$ 18,972	20	\$ 356
6/4/2015	O'CONNELL FIRE PROTECTION - FIRE SPRINKLERS	\$ 13,025	10	\$ 488
3/11/2015	WJS MECHANICAL -DAIKIN CHILLER	\$ 22,135	20	\$ 415
9/10/2015	WJS MECHANICAL - AC VALVE ACTUATOR	\$ 1,373	10	\$ 52
<b>Total additions for Building Improvements</b>		\$ 79,319		\$ 2,165 *
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$ -		\$ - **

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

\*Ties to Page 23, Line C3





**Annual Report of Long-Term Care Facility**

CSP-24 Rev. 10/2006

**Amortization Schedule\***

Name of Facility WORCESTER SKILLED CARE CENTER, INC			License No. 0723MA		Report for Year Ended 9/30/2015			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
<b>D. Total Amortization</b>									

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

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

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

Name of Facility WORCESTER SKILLED CARE CEN	License No. 0723MA	Report for Year Ended 9/30/2015	Page 25	of 37	
<b>11. Property Questionnaire</b>					
<b>Part A</b>					
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> 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 <b>NOT</b> 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					
<b>Part B - Owner and Related Parties</b>		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 9/30/2015					
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>					
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					
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	
Capital Care Properties, Inc., 10350 Ormsby Park Place, Suite 30 Louisville, KY 40223	Land & Building	01/31/06	1/31/06-2/1/20	1,550,081	

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

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

Name of Facility		License No.	Report for Year Ended			Page	of
WORCESTER SKILLED CARE CE		0723MA	9/30/2015			26	37
Item		Total	CCNH	RHNS	Other		
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. <b>Total Building Interest Expense</b> (A1 - A4 + B5)		\$					

*(Carry Subtotals forward to next page)*

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

Name of Facility		License No.		Report for Year Ended			Page	of
WORCESTER SKILLED CARE C		0723MA		9/30/2015			27	37
Item				Total	CCNH	MA Neuro	CT/NY Neuro	
Subtotals Brought Forward:								
12. C. Movable Equipment								
1. Automotive Equipment				\$				
A. Item		Rate	Amount					
Lender								
Address of Lender								
2. Other (Specify)				\$				
A. Item		Rate	Amount					
Lender								
Address of Lender								
B. Item		Rate	Amount					
Lender								
Address of Lender								
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$				
12. D. Other Interest Expense (Specify)				\$	1,910	1,407	59	444
Interest Working Capital								
13. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>				\$	1,910	1,407	59	444
14. Insurance								
a. Insurance on Property (buildings only)				\$	12,000	8,842	369	2,789
b. Insurance on Automobiles				\$				
c. Insurance other than Property (as specified above)								
1. Umbrella (Blanket Coverage)				\$	113,148	83,372	3,478	26,297
2. Fire and Extended Coverage				\$				
3. Other (Specify)				\$				
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$	125,148	92,215	3,847	29,086
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$	17,591,311	9,693,439	820,016	7,077,856

### D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENTER, INC				0723MA	9/30/2015	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	MA Neuro	CT/NY Neuro
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.	10	12.n.	Salaries not related to Resident Care	\$ 76,383	56,282	2,348	17,752
3.	10	12.g.	Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1.c	Bad Debts	\$ 95,203	70,150	2,927	22,126
10.	15	1.e	Accounting & Legal	\$ 41,774	30,781	1,284	9,709
11.			Telephone	\$			
12.	15	1.h.2	Cellular Telephone	\$ 1,227	904	38	285
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m.2 &	Unallowable Advertising *	\$ 10,070	7,420	310	2,340
19.			Income Tax / Corporate Business Tax	\$			
20.	16	m.4	Fund Raising / Contributions	\$ 200	147	6	46
21.			Unallowable Management Fees	\$			
22.	30	IV.7	Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 38,672	28,498	1,192	8,982
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
<b>Subtotal (Items 1 - 26)</b>				\$ 263,529	194,183	8,105	61,242

\* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

**Schedule of Other Salaries Adjustment**

Page Ref	Line Ref	Description	CCNH	MA Neuro	CT/NY Neuro
<b>Total Other Salaries Adjustment</b>			\$ -	\$ -	\$ -

**Schedule of Fees Adjustments**

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

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	MA Neuro	CT/NY Neuro
16	M13	LATE CHARGES	\$ 16,939	\$ 707	\$ 5,343
15	1A	MARKETING BENEFITS EST 76,383 X 18%	\$ 10,133	\$ 426	\$ 3,190
16	M3	MISC ESPENSE	\$ 394	\$ 16	\$ 124
16	M8	ESTIMATED LOBBY DUE MECF AND AHCA	1032	43	325
<b>Total Other A&amp;G Adjustments</b>			\$ 28,498	\$ 1,192	\$ 8,982

**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	9/30/2015	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	MA Neuro	CT/NY Neuro
Subtotals Brought Forward				\$ 263,529	194,183	8,105	61,242
<b>Page 20 - Resident Care Supplies***</b>							
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	\$			
<b>Page 22 - Maintenance and Property</b>							
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	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$			
<b>Not For Profit Providers Only</b>							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51.	<b>Total Amount of Decrease (Items 1 - 50)</b>			\$ 263,529	194,183	8,105	61,242

\*\*\* 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.

WORCESTER SKILLED CARE CENTER, INC  
9/30/2015

**Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	CCNH	RHNS	Other
<b>Total Other Ancillary Costs</b>			\$ -	\$ -	\$ -

**Schedule of Excess Movable Equipment Depreciation**

Page Ref	Line Ref	Description	CCNH	RHNS	Other
<b>Total Excess Movable Equipment Depreciation</b>			\$ -	\$ -	\$ -

**Schedule of Other Property Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	Other
<b>Total Other Property Adjustments</b>			\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	Other
<b>Total Other Adjustments</b>			\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Other
<b>Total Unallowable Building Interest</b>			\$ -	\$ -	\$ -

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended			Page	of
WORCESTER SKILLED CARE CENTE	0723MA	9/30/2015			30	37
Item	Total	CCNH	MA Neuro	CT/NY Neuro		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 1,525,498			1,525,498		
b. Medicaid Room and Board Contractual Allowance **	\$					
2. a. Medicaid ( <i>All other states</i> )	\$ 13,048,278	9,614,544	401,137	3,032,597		
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 597,481	597,481				
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$ 1,856,071	1,856,071				
b. Private-Pay Room and Board Contractual Allowance **	\$					
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 91,391	91,391				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (91,391)	(91,391)				
c. Prescription Drugs - Non-Medicare	\$ 207,456	51,864		155,592		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (182,597)	(27,005)		(155,592)		
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	\$ 257,435	257,435				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (158,914)	(158,914)				
c. Physical Therapy - Non-Medicare	\$ 131,603	32,901		98,702		
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (131,020)	(32,318)		(98,702)		
4. a. Speech Therapy - Medicare	\$ 139,755	139,755				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (89,499)	(89,499)				
c. Speech Therapy - Non-Medicare	\$ 124,126	31,032		93,095		
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (124,517)	(31,423)		(93,095)		
5. a. Occupational Therapy - Medicare	\$ 219,025	219,025				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (147,291)	(147,291)				
c. Occupational Therapy - Non-Medicare	\$ 180,511	45,128		135,383		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (156,649)	(21,266)		(135,383)		
6. a. Other ( <i>Specify</i> ) - Medicare	\$ (4,539)	(4,539)				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 4,211	4,211				
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 17,296,424	12,337,192	401,137	4,558,095		
<b>IV. Other Revenue*</b>						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income ( <i>Specify</i> )	\$ 422	311	13	98		
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$ 5,721	4,215	176	1,330		
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 6,143	4,526	189	1,428		
<b>VI. Total All Revenue</b> (III +V)	\$ 17,302,567	12,341,718	401,326	4,559,523		

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

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

**Schedule of Other Resident Revenue - Medicare**

**Related Exp**

Page Ref	Description	CCNH	MA Neuro	CT/NY Neuro
30II6A-CCH	X-Ray	\$ 4,968		
30II6A-CCH	Oxygen	\$ 730		
30II6A-CCH	Lab	\$ 11,020		
30II6A-CCH	IV	\$ 13,650		
	Contractual Allowance	\$ (34,907)		
<b>Total Other Resident Revenue - Medicare</b>		<b>\$ (4,539)</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Non-Medicare Resident Revenue**

**Related Exp**

Page Ref	Description	CCNH	MA Neuro	CT/NY Neuro
30II6b-CCH	Xray, CME, OXYGEN, LAB, IV - NON MEDICARE	\$ 3,001		\$ 57,028
30II6b-CCH	Contractual Allowance	\$ 1,210		\$ (57,028)
30II6b-CCH				
30II6b-CCH				
30II6b-CCH	Contractual Allowance			
<b>Total Other Resident Revenue</b>		<b>\$ 4,211</b>	<b>\$ -</b>	<b>\$ -</b>

**Interest Income**

**Account**

Page Ref	Account	Balance	CCNH	MA Neuro	CT/NY Neuro
30IV5-CCH	Interest Income		\$ 311	\$ 13	\$ 98
<b>Total Interest Income</b>			<b>\$ 311</b>	<b>\$ 13</b>	<b>\$ 98</b>

**Schedule of Other Revenue**

Page Ref	Description	CCNH	MA Neuro	CT/NY Neuro
	Special Billing	\$ 2,045	\$ 85	\$ 645
	Bade Debt Recovery	\$ 1,152	\$ 48	\$ 363
	Other Income	\$ 1,018	\$ 42	\$ 321
<b>Total Other Revenue</b>		<b>\$ 4,215</b>	<b>\$ 176</b>	<b>\$ 1,330</b>

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENT	0723MA	9/30/2015	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	96,816
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,459,840
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	15,478
4. Inventories			\$	17,104
5. Prepaid Expenses			\$	136,912
a. Prepaid Interest	1,431			
b. Prepaid Insurance	88,556			
c. {re[aod Workers Comp	28,658			
d. Prepaid Taxes 846 Prepaid Other Exp 17,421	18,267			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	49,231
Net Payroll	2,004			
Employee Loan	11,263			
Patient Exchange 11,485 Exchange Other 3,877	15,363			
Refund Contra	20,601			
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	1,775,381
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost <u>606,233</u>		\$	372,464
	Accum. Depreciation <u>233,769</u>	Net		
4. Leasehold Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>637,825</u>		\$	182,268
	Accum. Depreciation <u>455,557</u>	Net		
7. Motor Vehicles	*Historical Cost <u>51,226</u>		\$	
	Accum. Depreciation <u>51,226</u>	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	554,732

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

(Carry Total forward to next page)

### G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
WORCESTER SKILLED CARE CENT	0723MA	9/30/2015	32	37
Account			Amount	
Total Brought Forward:			\$	2,330,113
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 <b>Total Leasehold or Like Properties</b> (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	1,561
2. Escrow Deposits			\$	70,345
3. Organization Expense			*Historical Cost _____	
			Accum. Depreciation _____	Net
			\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care ( <i>itemize</i> )			\$	
_____				
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	(879,706)
Name and Address		Amount	Loan Date	
		(879,706)		
7. Other Assets ( <i>itemize</i> )			\$	2,400
Construction in Progress				2,400
_____				
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	(805,400)
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$	1,524,713

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

**G. Balance Sheet (cont'd)**

Name of Facility WORCESTER SKILLED CARE CENTER, I		License No. 0723MA	Report for Year Ended 9/30/2015	Page 33	of 37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	843,498
2. Notes Payable ( <i>itemize</i> )				\$	
_____					
_____					
_____					
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$	307,736
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	19,292
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable ( <i>Current Portion</i> )				\$	
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities ( <i>itemize</i> )				\$	1,111,781
Reserve for Medicare Rate Adj		(1,214)	Accrued User Fee	272,100	
A/P Patient Trust/PNA		91,320	Accrued Professional Ser	9,850	
Uncashed Checks		1,024	401K Withheld	7,108	(3,575)
Accrued Expenses		135,407	Deferred Rent	606,869	
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>				\$	<b>2,282,307</b>

\* 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 WORCESTER SKILLED CARE CENTER	License No. 0723MA	Report for Year Ended 9/30/2015		Page 34	of 37
Account				Amount	
Total Brought Forward:				2,282,307	
<b>Liabilities (cont'd)</b>					
B. Long-Term Liabilities					
1. Loans Payable-Equipment ( <i>itemize</i> )					
				\$	
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$	
Name and Address of Lender	Amount	Loan Date			
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$	
_____					
_____					
_____					
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 2,282,307	

**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	9/30/2015	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
<b>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	2,812,488
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(3,281,338)
6. Gain or Loss for Period			\$	(288,744)
	10/1/2014	thru	9/30/2015	
7. Total Net Worth			\$	(757,594)
<b>C. Total Reserves and Net Worth</b>			\$	(757,594)
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	1,524,713

### H. Changes in Total Net Worth

Name of Facility WORCESTER SKILLED CARE CENT	License No. 0723MA	Report for Year Ended 9/30/2015	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2014			\$	168,134
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$	17,302,567
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$	17,591,311
D. Net Income or Deficit			\$	(288,744)
E. Balance			\$	(120,610)
F. Additions				
1. Additional Capital Contributed ( <i>itemize</i> )				
2. Other ( <i>itemize</i> )				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )			\$	
Name and Address ( <i>No., City, State, Zip</i> )		Title	Amount	
2. Other Withdrawings ( <i>Specify</i> )			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. <b>Balance at End of Period</b>			\$	(120,610)
				09/30/15

### I. Preparer's/Reviewer's Certification

Name of Facility WORCESTER SKILLED CARE	License No. 0723MA	Report for Year Ended 9/30/2015	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> Other		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
CLIFTONLARSONALLEN LLP				
Address Address			Phone Number	
300 Crown Colony Dr., Ste 310, Quincy, MA 02368			617-984-8100	

## Error Check

Level	Item	Reported as		
	Page 22 - Movable Depreciation	80,988	is inconsistent with Page 23	80,988
	Page 22 - Leasehold and Other Amortization	-	is inconsistent with Page 24	-
	Page 23 - Historical Cost of Motor Vehicles	51,226	is inconsistent with Page 31	51,226
	Page 23 - Historical Cost of Movable Eq.	637,825	is inconsistent with Page 31	637,825
	Page 23 - Accumulated Dep. of Motor Vehicles	51,226	is inconsistent with Page 31	51,226
	Page 23 - Accumulated Dep. of Movable Eq.	455,557	is inconsistent with Page 31	455,557
	Page 24 - Historical Cost of Leasehold Imp.	-	is inconsistent with Page 31	-
	Page 24 - Accumulated Amort. of Leasehold Imp.	-	is inconsistent with Page 31	-
-	Page 35 - Total Liabilities, Reserves and Net Worth	1,524,713	Total Assets	1,524,713